



For Your BENEFIT

STATE OF LOUISIANA • OFFICE OF GROUP BENEFITS

OGB transitions to new Medicare Part D prescription coverage with wrap-around

On January 1, 2012, the Office of Group Benefits moved to a new Medicare Part D prescription drug plan for some members that includes supplemental coverage to provide benefits in the coverage gap or “donut hole.” The new plan is administered by Medco.

Enrollment is automatic (at no extra cost) for any member who:

- Is retired;
- Has Medicare Part A and/or Part B coverage; and
- Is enrolled in the OGB PPO or Blue Cross HMO health plan.

The change does not affect members who are still working, disabled dependents, dependent children or members enrolled in other OGB health plans.

Why OGB made this change

Federal subsidy dollars are important because the money helps OGB offset rising health care costs and minimize future premium increases. For several years, OGB has received a federal Retiree Drug Subsidy (RDS) for providing prescription coverage to retired members with Medicare, but this subsidy is being phased out. By transitioning these OGB members

to OGB’s new Medco Medicare prescription drug plan for 2012, OGB qualifies to receive the new Employer Group Waiver Program (EGWP) subsidy.

What the change means

Members affected by the transition can expect to see very little, if any, change in prescription benefits.

- Supplemental coverage with benefits in the coverage gap or “donut hole” means members have more drug coverage than standard Medicare D plans:
 - o No change in drug co-insurance
 - o Continued availability of diabetic supplies at \$0 co-pay
 - o Little or no change in the pharmacy network
 - o Continued coverage for most prescriptions now covered by Catalyst Rx
 - o Coverage for some drugs not previously covered
 - o Quantity limits that may be different
 - o Prescription fill limits of up to 31, 62 and 93 days (instead of 30, 60 and 90 days)
 - o Up to a 93-day fill at many network retail pharmacies – without a 31-day wait.

- Prescriptions that previously required prior authorization probably require a new prior authorization. (Catalyst Rx sent each affected member a letter listing prescriptions that require a new prior authorization, which the member has 30 days to obtain.)
- Affected members now have two OGB ID cards – one for medical benefits and a second for prescription benefits only. Retirees in other health plans who are not affected did not receive a Medco ID card.

Low-income subsidy

Affected low-income members may qualify for a Medicare subsidy (known as “extra help”) to help pay prescription co-payments and reduce the prescription portion of the member’s health plan premium. Eligibility is determined by the federal Centers for Medicare and Medicaid Services (CMS). The CMS guidelines for 2012 allow a maximum annual income of \$13,070 for one person, or \$26,120 for a married couple, to qualify for the subsidy.

CMS-required mailings

Medco is mailing information to affected members to explain the

(continued on page 2)

OGB weight loss study gets underway in 2012

Members enrolled in OGB's PPO health plan (administered by OGB), HMO health plan (administered by Blue Cross) and CDHP (administered by UnitedHealthcare) may be eligible to participate in a new OGB weight loss program designed by Pennington Biomedical Research Center in Baton Rouge.

The program, called Heads Up, begins later this year for members who are severely overweight and suffering weight-related health problems. It includes a bariatric surgery component and an intensive medical treatment component.

Each PPO, HMO (Blue Cross) and CDHP plan member will receive a letter with details about the program. These letters are being mailed by zip code, beginning in January and continuing through March. This mailing schedule is designed to allow Pennington Biomedical adequate time to respond to eligible OGB members who indicate interest in participating in the program.

The letter includes information about the program and eligibility requirements, plus the web address



(URL) for the Heads Up program website. The website contains more details about the program, including informational videos describing the weight-loss surgery and intensive medical treatment for obesity.

After reviewing the information on the website about both components of the program, members who are interested in participating can complete a short online questionnaire to determine their eligibility to begin the screening process.

Despite the staggered mailing dates, all PPO, Blue Cross HMO and CDHP members who indicate interest by completing the online questionnaire have an equal opportunity to be considered for participation in the Heads Up program.

Medicare Part D coverage (continued from page 1)

new Medco Medicare prescription drug plan and supplemental coverage. Much of this information is required by CMS and contains language that may be confusing and may not apply to your OGB coverage. OGB encourages members to carefully read and save all of this information.

Consequences of opting out

The letters affected members receive in the mail from Medco include CMS-required "opt-out" language that explains how to opt out of OGB's Medco Medicare Part D drug coverage. **OGB strongly recommends not opting out of OGB's Medco Medicare Part D coverage.** By opting out of OGB's Medco Medicare Part D prescription drug plan, affected members automatically opt out of **all** of their OGB health and prescription drug coverage – for themselves and their family members.

CMS enrollment rules for Medicare plans

CMS rules allow each person to be enrolled in only one Medicare-type plan. Because affected members

have been enrolled automatically in OGB's Medicare Part D prescription plan effective January 1, **OGB also strongly recommends not purchasing or enrolling in:**

- An individual Medicare Advantage plan; or
- A non-OGB group Medicare Advantage plan; or
- Another Medicare Part D plan for drug coverage only.

If you have been enrolled automatically, signing up for ANY individual Medicare plan cancels your current OGB health and prescription coverage – and could leave you and your covered family members without any OGB health and prescription coverage! OGB urges you to contact OGB Customer Service before opting out to be sure you fully understand the consequences of your decision.

If you have questions about your new OGB Medco Medicare Part D prescription drug coverage for 2012, call Medco toll-free at 1-866-808-5271 or 1-800-716-3231 (TTY/TDD). Customer service representatives are available 24 hours a day, 7 days a week.

Nurtur to administer Living Well Louisiana program

Effective January 1, 2012, OGB's Living Well Louisiana health management program will be administered by Nurtur. The program, previously administered by Health Dialog, will continue to use the same toll-free number.

The Living Well Louisiana program is available to OGB members who:

- Are enrolled in OGB's standard PPO or HMO (Blue Cross) health plans;
- Do not have Medicare as primary health coverage; and
- Have been diagnosed with one or more of five ongoing health conditions – diabetes, heart disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD).

The program offers health coaching by registered nurses, dietitians, and pharmacists, who provide educational materials and offer caring support, plus a cost-saving prescription drug incentive.

The incentive offers active LWL participants reduced co-payments on prescribed medications for any of the five targeted conditions with which they have been diagnosed – only \$15 for brand-name drugs or \$0 for generics (for a 31-day supply) – instead of the standard 50 percent co-insurance (up to \$50 for a 31-day supply).



To receive these valuable benefits, an OGB member must be actively engaged in the LWL program and participate in at least one coaching call every 90 days – a telephone call to or from a Nurtur LWL health coach.

(Receiving educational materials by mail, listening to pre-recorded phone messages and sending or receiving health coach emails do not meet this requirement.)

OGB requires that all active participants talk to a Living Well Louisiana health coach between January 1 and March 31, 2012. Participants must fulfill this requirement to remain eligible to receive the benefits of this valuable health management program, including the reduced prescription drug co-payment incentive.

If you are participating in the program and have not yet scheduled a telephone contact with an LWL health coach in 2012, it is important to do so soon.



Living Well Louisiana

FLU VACCINATIONS

OGB's PPO, HMO, Regional HMO, Medical Home HMO and CDHP-HSA health plans cover flu shots

Flu shots can be administered at doctor's offices, health fairs, hospitals, medical clinics and pharmacies

Immunization shots for influenza are a covered benefit under OGB's PPO, HMO, Regional HMO, Medical Home HMO and CDHP-HSA health plans whether the shot is administered at a doctor's office, health fair, hospital, medical clinic or pharmacy.

Claims for flu shots are processed by each OGB health plan subject to any applicable co-payment and deductible. If your plan has an annual deductible and you have not yet met that deductible, the claim is applied to the deductible and the plan pays any amount that exceeds the deductible. If your plan has no deductible but requires a co-payment, the plan will reimburse you for the amount that exceeds your co-payment.

If you receive your flu shot from a doctor's office or medical clinic that is a participant in your health plan's network, the medical facility will file a claim for you.

If you receive your flu shot at a pharmacy and your pharmacy agrees to file a claim directly with your health plan provider, no action by you is needed.

However, if the doctor or pharmacy does not file a claim for you, you must file a claim to receive benefits. Here are the steps you need to take...

1. Get your flu shot and pay for it. If you have an OGB general-purpose flexible spending arrangement (GPFSA) card, do not use it to pay for the vaccine. Be sure the receipt includes the date administered, the cost, the vaccine name, the name of the person who received the shot and the medical provider or pharmacist who administered it.
2. To file a claim, visit the OGB website (www.groupbenefits.org), and click on the Flu Information icon on the home page. Find your health plan, and click on the link to the claim form. Complete the form online and print it, or print a blank form and fill it in, using blue or black ink. Sign and date the form. Mail the form and the original receipt (not a cash register receipt or a copy) to the address listed on the form.

HEALTH PLAN	COVERED BENEFIT
PPO <i>(Administered by OGB)</i>	Covered at 90%; subject to deductible
HMO <i>(Administered by Blue Cross & Blue Shield of Louisiana)</i>	Covered at 100% of allowable amount; no deductible
Regional HMO <i>(Fully insured by Vantage Health Plan)</i>	Covered at 100% of allowable amount; no deductible
Medical Home HMO <i>(Fully insured by Vantage Health Plan)</i>	Covered at 100% of allowable amount; no deductible
CDHP-HSA <i>(Administered by UnitedHealthcare)</i>	Covered at 80%; subject to deductible

Prescription fill limits increased for 2012 for PPO, Blue Cross HMO and CDHP plans

Starting in 2012, prescription fill limits have increased for OGB's standard PPO, HMO (Blue Cross) and CDHP-HSA health plans. The new fill limits are for 31-day, 62-day and 93-day supplies.

For the PPO and HMO plans, the maximum out-of-pocket expense for the member is \$50 per 31-day fill for generic drugs and brand-name drugs with no available generic. The out-of-pocket maximum is \$1,200 per person, per plan year. After reaching the \$1,200 maximum, the member has a co-pay of \$15 for brand-name drugs and \$0 for generic drugs.

For brand-name drugs with a FDA-approved generic available, the member pays the cost difference between the brand-name drug and the generic, plus 50 percent of the brand-name drug cost. This cost

difference does not count toward the member's \$1,200 out-of-pocket maximum. The costs for the mail-order program are the same as stated above.

For the CDHP-HSA, co-pays are as follows:

- Generic drugs - \$10 co-pay
- Preferred brand drugs - \$25 co-pay
- Non-preferred brand drugs - \$50 co-pay
- Specialty drugs - \$50 co-pay

CDHP prescription co-payments for a 90-day supply through the mail-order program are the same as the amounts listed above.

For the Regional HMO and Medical Home HMO plans, both fully-insured by Vantage Health Plan, the fill limits remain at 30-day, 60-day and 90-day supplies.

For the Regional HMO plan, the maximum out-of-pocket expense for the member is \$50 per 30-day fill for generic drugs and brand-name drugs for which no FDA-approved generic is available. There is a \$1,200 out-of-pocket maximum.

For the Medical Home HMO, the co-pay for a 30-day fill is \$5 for a generic drug, \$30 for a preferred brand drug, \$50 for a non-preferred brand drug and 20 percent co-insurance for a specialty drug.

Prescription co-payments for the Regional HMO and Medical Home HMO plans' mail-order programs are based on the amounts listed in the previous two paragraphs. The member pays one co-payment for a 30-day supply, two co-payments for a 60-day supply and three co-payments for a 90-day supply.



DHH PILOT PROGRAM

DHH pilot program offers expanded tobacco cessation

Louisiana state employees who want to quit smoking now have a greater likelihood of success, thanks to a Department of Health and Hospitals (DHH) pilot program that offers free expanded cessation coaching through the Louisiana Tobacco Quitline (1-800-QUIT-NOW).

Tobacco use is the leading cause of preventable death in Louisiana, claiming the lives of nearly 6,500 residents each year. In addition, tobacco use is a leading risk factor for a number of chronic diseases—such as cancer, lung disease and heart disease—that are life-threatening and costly to residents and to the state.

Smokers who are ready to quit are encouraged to enroll in free telephone coaching through the Louisiana Tobacco Quitline (1-800-QUIT-NOW), which is jointly managed by the Louisiana (DHH) Tobacco Control Program and the non-profit Louisiana Campaign for Tobacco-Free Living. Program participants receive free coaching and support through certified quit coaches who work with each caller to develop a personalized quit plan.

Through the DHH pilot program, state employees qualify for up to five scheduled coaching sessions as well as web-based services through the Quitline's web coach program. The pilot program is made possible through a federal grant from the U.S. Centers for Disease Control and Prevention.



The Quitline is also available 24 hours a day, seven days a week, for all Louisiana residents over the age of 13, but the number of coaching sessions offered may be limited and is based on certain qualifications, such as pregnancy or the type of insurance coverage.

"According to the U.S. Centers for Disease Control and Prevention, 70 percent of current smokers report that they want to quit, but only about four to seven percent will be successful if their quit attempt is unaided," said Tiffany Netters, interim director of the DHH Chronic Disease Prevention and Control Unit. "By using a combination of behavioral therapy like Quitline coaching along with cessation medications, someone trying to quit can more than double the chances of success."

Most OGB members are eligible to receive tobacco cessation medications with no co-payments through their prescription drug coverage. The medications included in the benefit are nicotine replacement therapy (NRT) drugs, which come in the form of gum, patches, inhalers, nasal spray and lozenges, as well as the prescription medications Bupropion (Zyban or Wellbutrin) and Varenicline (Chantix). These U.S. Food and Drug Administration (FDA)-approved medications are known to decrease the urge to smoke and can double a smoker's chances of quitting successfully.

Support for state employees

OGB health plan coverage for each of the seven FDA-approved cessation medications requires a written prescription, even for those sold over the counter.

The first step for an employee planning to quit should be to call the Louisiana Tobacco Quitline (1-800-QUIT-NOW) to get registered for coaching support during the quitting process. The quit coach then develops an individualized quit plan. If a participant is interested in receiving prescription or over-the-counter cessation medications using OGB health plan benefits, the quit coach will guide him

or her through the process of visiting a network physician, who will determine which cessation aid is medically appropriate for that individual. An OGB member seeking medication to quit using tobacco must then discuss his or her quit plan with the health care provider and obtain a prescription for the cessation medication.

Check with your health plan to determine your plan's coverage for tobacco cessation medications. For more information about tobacco cessation and the Louisiana Tobacco Quitline, visit www.QuitWithUsLA.org.

Five Steps to Achieving Success



Louisiana Tobacco Quitline (1-800-QUIT-NOW)

Join us online at www.QuitWithUsLA.org • [Facebook.com/QuitWithUsLA](https://www.facebook.com/QuitWithUsLA) • [Twitter @QuitWithUsLA](https://twitter.com/QuitWithUsLA)

MEDICARE ELIGIBILITY

Are you almost 65?

OGB considers Medicare primary health care coverage for all retired OGB plan members and dependents, regardless of the OGB health plan in which you are enrolled. If you are eligible to enroll in premium-free Medicare Part A hospitalization coverage, you **MUST** also enroll (and remain enrolled) in Medicare Part B medical coverage (for which you must pay a premium) to continue receiving benefits from your OGB health plan for medical claims.

This applies to you (and your spouse, if covered by your OGB health plan) if you:

- Reached age 65 on or after July 1, 2005; and
- Are eligible for Medicare Part A as an individual or as a dependent of your current or previous spouse.

If you or your covered spouse are retired but are not yet age 65, this will apply to you when you reach age 65.

This does not apply to you or your covered spouse if you:

- Reached age 65 before July 1, 2005; or
- Are not eligible for premium-free Medicare Part A.

If you are eligible for premium-free Part A but do not enroll in Part B during the 7-month period when you are first eligible to sign up (the 3 months before your birthday month, your birthday month and the 3 months after):

- You must wait to enroll during the fall annual enrollment period



- Your Medicare Part B premium increases by 10 percent for each 12-month period in which you were not enrolled after you first became eligible.

To avoid unnecessary out-of-pocket costs, OGB recommends you and your covered spouse visit the nearest Social Security Administration office *about 90 days before you reach age 65* to determine if you are eligible for Medicare and to enroll if you are.

If you are eligible for Medicare:

Apply for both Part A and Part B coverage. When you receive your Medicare card, send a copy to:

**Office of Group Benefits
P.O. Box 66678
Baton Rouge, LA 70896**

After OGB receives a copy of your Medicare card, Medicare becomes your primary health coverage and your OGB health plan premiums are reduced.

If you are not eligible for Medicare:

Obtain a letter or other written verification from the Social Security Administration confirming you are not eligible. Send a copy to OGB at the address above.

After OGB receives a copy of SSA documents verifying your ineligibility, your OGB health plan remains your primary coverage with no change in your premiums.

Applying for Medicare *90 days before* you or your covered spouse reach age 65 ensures that Medicare coverage begins when you reach age 65. It also allows time for OGB to receive documents required to continue paying medical benefits *with no lapse in your OGB health coverage.*

Coverage offered for OTC proton pump inhibitor medicine

The prescription drug benefit for the PPO and HMO (Blue Cross) health plans covers over-the-counter (OTC) proton pump inhibitor (PPI) medications for heartburn and gastroesophageal reflux disease (GERD) – if the member has a prescription from a physician. The prescription must clearly say “OTC” on it.

The member pays 50 percent of the cost of these OTC PPIs at the time of purchase (up to a \$50 maximum per prescription for up to a 31-day supply.) Since package sizes are usually sold in counts of 14, 28 or 42 pills or capsules, it is important for the OGB member’s physician to take this into account when writing the prescription.

For example, to get a 93-day supply of your medicine, ask your doctor to write your prescription for two boxes of the 42-count, if you take one pill a day. Once you have the prescription, you would hand the two boxes of the 42-count pills and the prescription to the

pharmacist. The member must pay a co-pay for each full or partial 31-day supply, which means you would pay three co-payments for this 93-day supply.

The following OTC PPI medications are covered:

- Prevacid 24 Hour
- Prilosec OTC
- omeprazole (store brand of Prilosec)
- Zegerid OTC

In the near future, store brands for Prevacid and Zegerid will be available as:

- lansoprazole (Prevacid 24 Hour)
- omeprazole and sodium bicarbonate (Zegerid OTC)

These OTC PPI medications are equally effective for most people and far less costly than prescription PPIs. In cases where your doctor determines it is appropriate for you to use less expensive OTC PPIs, doing so will save money for both you and your health plan.

PPI Medication Cost Comparison...

Prescription PPI Medications	Member Cost	Health Plan Cost	* Total Cost
Aciphex	\$50.00	\$201.77	\$251.77
Nexium	\$50.00	\$167.82	\$217.82
Dexilant	\$50.00	\$81.76	\$131.76
Pantoprazole	\$50.00	\$71.41	\$121.41
OTC PPI Medications	Member Cost	Health Plan Cost	** Retail Cost
Prilosec OTC 20 mg (14-count)	\$6.49	\$6.50	\$12.99
Prilosec OTC 20 mg (28-count)	\$10.99	\$11.00	\$21.99
Prilosec OTC 20 mg (42-count)	\$14.49	\$14.50	\$28.99
omeprazole OTC 20 mg (14-count)	\$4.99	\$5.00	\$9.99
omeprazole OTC 20 mg (28-count)	\$8.99	\$9.00	\$17.99
omeprazole OTC 20 mg (42-count)	\$11.49	\$11.50	\$22.99
Prevacid 24HR 15 mg (14-count)	\$6.49	\$6.50	\$12.99
Prevacid 24HR 15 mg (28-count)	\$10.99	\$11.00	\$21.99
Prevacid 24HR 15 mg (42-count)	\$14.49	\$14.50	\$28.99
Zegerid OTC 20-1100mg (14-count)	\$6.49	\$6.50	\$12.99
Zegerid OTC 20-1100mg (28-count)	\$10.99	\$11.00	\$21.99
Zegerid OTC 20-1100mg (42-count)	\$14.49	\$14.50	\$28.99

* Average costs based on prices from 2010 calendar year.

** Prices are approximate and may vary by retailer.

PRESCRIPTION MANAGEMENT

New Catalyst Rx Mobile online application offers innovative tools for members in PPO, HMO plans



Catalyst Rx, prescription drug benefit administrator for OGB's standard PPO and HMO (Blue Cross) health plans, has developed Catalyst Rx Mobile, an array of innovative tools to be used on your mobile phone or personal computer. The new mobile application uses the latest secure online technology to help you quickly research benefit and claim information, find a nearby pharmacy, compare drug costs at retail and mail service pharmacies, track your prescription history and more, all while lowering your prescription drug costs.

The new Catalyst Rx Mobile tools include the following:

- **Catalyst Price & Save** – identifies lowest-cost drug and pharmacy options
- **Therapeutic Advantage** – compares prices across lower-cost drug alternatives when a generic drug equivalent is not available
- **Covered Drug Lists** – displays a list of medications covered by your health plan
- **Co-Payment Information** – compares costs of preferred and non-preferred medications at retail and mail service pharmacies
- **My Prescription** – tracks your prescriptions and expense history
- **Locate Pharmacies** – searches Catalyst Rx's network of more than 60,000 pharmacies to locate the nearest pharmacy and provide directions, phone numbers and more
- **Drug Dictionary** – provides information on specific medications, including common uses, precautions, side effects and warnings.

PPO and HMO members can access Catalyst Rx Mobile free of charge on a variety of mobile devices or by visiting the Catalyst Rx website. Members can follow these steps to download a free application for iPhone, iPod Touch, iPad, Blackberry and Android:

- Enter the Catalyst Rx website address (www.catalystrx.com) into your phone's browser;
- Bookmark the site by clicking on + at the bottom of the screen and selecting **Add to home screen**.

Catalyst Rx Mobile was developed after more than a year of consultation with experts in the areas of pharmacy, behavioral psychology and mobile health technology. Having this information at your fingertips can help you make informed decisions about your health care.

To learn more about Catalyst Rx Mobile, visit the Catalyst Rx website (www.catalystrx.com) and click on the Mobile dedicated web page or call Catalyst Rx toll-free at 1-866-358-9530.



Avoid balance-billing by using network providers

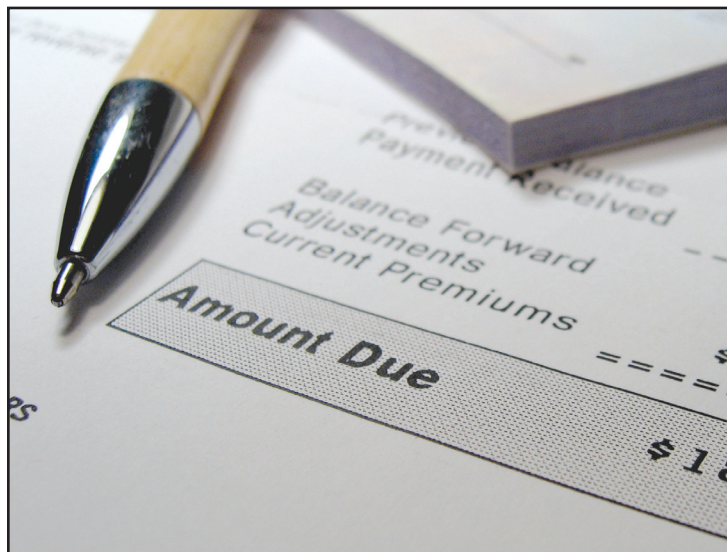
To ensure that Louisiana residents are aware of the financial implications of balance-billing by out-of-network providers at network facilities (such as out-of-network radiologists, pathologists, laboratories, hospitalists and emergency room physicians at network hospitals), Act 453 of the 2010 Louisiana Legislature requires health plans in Louisiana to provide the notice below to their members.

Balance-billing refers to the amount billed by an out-of-network provider that represents the difference between the amount the provider charges for a service and the amount the member's health coverage pays for the service.

When an OGB member uses a network provider, the provider has signed a contract with the member's health plan and agreed to accept assignment of OGB health plan benefits as payment in full, after any member co-payment or co-insurance. This negotiated price usually is lower than the amount the provider charges for the service because it reflects the increased number of patients and revenue the provider gains by providing health care services to the many members of that health plan.

Terms such as "out-of-network", "non-network" and "non-participating" all refer to providers who have not contracted with the member's OGB health plan.

When a member chooses an out-of-network provider, he or she chooses to accept financial responsibility



for any difference between the amount charged by the out-of-network doctor or physician group and the discounted amount paid by the member's OGB health plan for covered services rendered by network providers – which is the balance billed by the provider.

Because balance-billing can add up to thousands of dollars in unplanned medical expenses, OGB encourages each member to manage out-of-pocket costs by choosing network providers wherever possible and by checking in advance to determine if hospital-based providers are participating providers in his or her plan's network. An online provider directory for each OGB health plan is accessible via the OGB website (www.groupbenefits.org) and indicates the network participation status for hospital-based providers.

NOTICE

Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for co-payments, co-insurance, deductibles, and non-covered services.

Specific information about in-network and out-of-network facility-based physicians can be found at the website address of your health plan or by calling the customer service telephone number of your health plan.



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Vision

OGB envisions itself as a leader in improving and preserving quality of life.

Mission

OGB will offer an employee benefits system that meets or exceeds industry standards and/or benchmarks.

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