

# Annual Plan Notification

## NOTICE OF COMPLIANCE WITH RECENT CHANGES IN FEDERAL AND STATE HEALTH INSURANCE LAWS

State law requires health plans that provide mastectomy benefits also to provide certain related benefits and to tell participants they are available. *As a result, Health Plus is required by federal law to provide you with this notice. Please note that the health coverage offered by Health Plus already provides this coverage if the reconstruction is performed under the same plan or policy that the mastectomy was performed.*

Medical and surgical mastectomy benefits available under the medical plans offered by Health Plus include reconstruction of the breast on which the mastectomy was performed, surgical reconstruction of the other breast for symmetrical appearance, prostheses and treatment of other physical complications. These reconstructive benefits are subject to annual deductibles, copayments and coinsurance provisions like other medical benefits covered by Health Plus.

Please refer to your Health Plus Certificate of Coverage for additional details or call Health Plus Member Services at (318) 212-8520 or (800) 331-5500.

### Member Liability

You are required to pay copayments, deductibles, and coinsurance for covered services rendered by participating providers and non-participating providers. The copayments, deductibles, and coinsurance are set forth in your Schedule of Benefits and are due and payable at the time of receipt of covered services.

### Provider Access

- If you have a Health Plus HMO, Health Plus POS, or Health Plus DIRECT health plan, then you must select a primary care physician and comply with the following protocol.

*Primary Care Physician Choice.* You must select a primary care physician from the Health Plus Provider Directory at the time of your enrollment with Health Plus. You may only select a physician whose specialty is family practice, internal medicine, obstetrics/gynecology or pediatrics to serve as your primary care physician. Your primary care physician is indicated on your Health Plus Member ID Card. In some instances, you may not select a particular primary care physician in the Health Plus Provider Directory because such primary care physician cannot accept new patients.

*Specialist Physician Access.* If you have a Health Plus HMO or if you have a Health Plus POS health plan and you use your in-network Health Plus POS benefits, then you should obtain a referral from your primary care physician before you visit a specialist physician in the Health Plus Provider Directory.

*Point-of-Service (POS) and DIRECT.* Only if you have a Health Plus health plan with “POS” or “DIRECT” in the name can you visit primary care physicians and specialist physicians not listed in the Health Plus Provider Directory. In the event that you visit a primary care physician or specialist physician not listed in the Health Plus Provider Directory, the service is covered under the out-of-network benefit.

- If you have a Health Plus health plan with “CHOICE” in the name, then you are not required to select a primary care physician and you may visit any provider without a referral. When you visit a primary care physician or a specialist physician in the Health Plus Provider Directory, the in-network benefit applies, otherwise the service is either not covered (under Health Plus HMO CHOICE) or the out-of-network benefit applies (under Health Plus POS CHOICE).

## **Pre-existing Condition Exclusion**

Health Plus applies Pre-existing Condition Exclusion upon initial enrollment, open enrollment, date of hire, and special enrollment conditions as described in your Certificate of Coverage. Pre-existing Condition Exclusion means a condition, excluded from coverage for 12 months, for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding your initial date of coverage.

## **Provider Compensation**

Health Plus contracts with a variety of providers, including physicians, hospitals, and ancillary providers. These contracted providers are compensated according to the following—discounted fee-for-service, per diem, capitation and case rate.

## **Services and Treatments**

All Health Plus health plans meet the coverages mandated by the state of Louisiana. The coverages include, professional physician services, preventive care services, hospital services, diabetes management, home health care, hospice, pregnancy and maternity care, ambulance service, emergency services, skilled nursing, and mental health/substance abuse coverage. A complete description of the covered services and exclusions is provided in your Certificate of Coverage.

## **Experimental Treatments**

Health Plus does not cover experimental medical, surgical, pharmaceutical and other health care services, including without limitation certain organ transplants and bone marrow transplants, which procedures and transplants Health Plus determines, in accordance with generally accepted medical standards, are experimental. Services that are a part of a course of treatment directly related to such experimental procedures are also not covered. A complete description of the covered services and exclusions is provided in your Certificate of Coverage.

## **Prescription Drugs**

Health Plus covers prescription medications under a Three-Tier Copay Modified Open Formulary, which means that all prescription medications are covered, however some medications are specifically excluded from coverage as provided in your Certificate of Coverage. Under the Three-Tier Copay, drugs are assigned to different copay tiers based on cost and clinical considerations. Your copay is based on the tier into which the prescribed drug falls. Typically, you can reduce your out-of-pocket costs when using drugs that fall into generic or preferred drugs. The list of generic, preferred, and non-preferred drugs is sent to you with your Drug Benefit ID Card. You must use pharmacies contracted with PAID Prescriptions, L.L.C. to receive the benefits described in your Certificate of Coverage.

Some prescription drugs are subject to prior authorization and are eligible for coverage only after you receive specific approval from Merck-Medco. Your physician will provide the clinical information for approval. Prescription drug categories, including, but not limited to, migraine management, onychomycosis management, vaginitis therapy, NSAID therapy, and antiemetic therapy may be subject to quantity limitations to minimize your exposure to significant and unnecessary risk. You may request an appeal of the quantity limitation.

Additions or deletions to the list of preferred and non-preferred drugs are reviewed by an independent panel of physicians who evaluate drugs based on objective clinical and economic criteria. The list is also reviewed by local, independent members of the Pharmacy and Therapeutics, or P&T, Committee. In the clinical review process, the drug is assessed for its safety, efficacy, and effect on patient compliance. Finally, based on clinician and provider recommendations, the drugs are classified into the preferred and non-preferred tiers.