PPO Prescription Drug Coverage

Your prescription drug coverage is included with your medical plan and is provided through Elixir. It is designed to encourage the use of generic and preferred brand-name drugs in an effort to control growing prescription drug expenses. Other types of brand-name drugs are covered by the plan, but at higher copayments. For further information, see the chart below.

Mail order prescriptions are a convenient alternative for those who take regular maintenance medications. The PPO plan options allow a 90-day fill of tier 1, 2, and 3 drugs by mail order or through a retail pharmacy at 2.5 times the copay for a 30-day fill.

Prescription drug benefits are administered by Elixir. The prescription drug plan uses a list of preferred brand-name drugs. This list consists of carefully selected drugs that are considered safe and cost effective. The list may change from time to time, so you should check with Elixir before you have your prescription filled. The preferred drug list (formulary) may be viewed through a link on the Human Resources website.

Elixir Customer Care Team members are available at 1-855-476-7903.

Do you take a compound drug? All compound medications will require a prior authorization.

PPO PRESCRIPTION DRUG PLAN
(Does not apply to HDHP)

Options	Core	Basic	Plus
From a Participating Retail Pharmacy (30-day supply)			
• Tier 1: Generic (and certain brand-name)	$15 copay	$7 copay	$7 copay
• Tier 2: Brand-name drugs (and certain generic)	$35 copay	$30 copay	$30 copay
• Tier 3: Generic or brand-name drugs with therapeutic alternative	$75 copay	$50 copay	$50 copay
• Tier 4: Specialty Drugs	$150 copay	$150 copay	$150 copay
Mail Order			
• Tier 1: Generic (and certain brand-name)	$37.50 copay	$17.50 copay	$17.50 copay
• Tier 2: Brand-name drugs (and certain generic)	$87.50 copay	$75 copay	$75 copay
• Tier 3: Generic or brand-name drugs with therapeutic alternative	$187.50 copay	$125 copay	$125 copay
• Tier 4: Specialty Drugs	N/A	N/A	N/A

** Please note out-of-network prescriptions are not covered under the plan.*

If you have Medicare or will become eligible for Medicare within the next 12 months, Medicare Part D will give you more choices in your prescription drug coverage. Please review the Medicare Part D Notice of Creditable Coverage section on pages 53-54 for important information.

Contraception Drug Benefit: All female members will have access to these benefits by contacting Elixir to enroll in their plan that is not affiliated with Loyola University's medical insurance. A separate ID Card will be issued by Elixir to present to the pharmacy or provider at the time of service.

Contact Elixir at 1-855-476-7903. Covered hormonal contraceptive medications must be obtained through home delivery from Elixir (subject to your right to receive two courtesy fills at participating retail pharmacies).

LOYOLA PPO MEDICAL INSURANCE OPTIONS

Options	Core		Basic		Plus	
	In-Network (Tier 2)	Out-of-Network	In-Network (Tier 2)	Out-of-Network	In-Network (Tier 2)	Out-of-Network
Calendar Year Deductible	$1,500 Individual $4,500 Family	$2,000 Individual $6,000 Family	$1,500 Individual $4,500 Family	$1,500 Individual $4,500 Family	$500 Individual $1,000 Family	$1,000 Individual $3,000 Family
In-network services that require you to first meet your calendar year deductible before the plan starts paying coinsurance.						
Inpatient Hospital (includes maternity)	80% after deductible	60% after deductible	80% after deductible	70% after deductible	$200 copay per day, for the first 3 days only	70% after deductible
Outpatient Surgery (and physicians fee)	80% after deductible	60% after deductible	80% after deductible	70% after deductible	100% after deductible	70% after deductible
MRI/PET (major diagnostic) prior authorization required	80% after deductible	60% after deductible	80% after deductible	70% after deductible	100% after deductible	70% after deductible
Ambulance	80% after deductible	80% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
Inpatient Mental Health	80% after deductible	60% after deductible	80% after deductible	70% after deductible	$200 copay per day, for the first 3 days only	70% after deductible
Inpatient Substance Abuse	80% after deductible	60% after deductible	80% after deductible	70% after deductible	$200 copay per day, for the first 3 days only	70% after deductible
Skilled Nursing Facility (60 days per year)	80% after deductible	60% after deductible	80% after deductible	70% after deductible	$200 copay per day, for the first 3 days only	70% after deductible
Home Health Care (60 visits per year)	80% after deductible	60% after deductible	80% after deductible	70% after deductible	100% after deductible	70% after deductible
In-network services that require a flat copayment at the time of service.						
Urgent Care	$55 copay per visit	60% after deductible	$40 copay per visit	70% after deductible	$35 copay per visit	70% after deductible
Emergency Room Care (copayment waived if admitted)	$150 copay per visit	$150 copay per visit	$150 copay per visit	$150 copay per visit	$150 copay per visit	$150 copay per visit
Outpatient Mental Health	100% after $40 copay	60% after deductible	100% after $25 copay	70% after deductible	100% after $20 copay	70% after deductible
Office Visit Mental Health	$40 copay per visit	60% after deductible	$25 copay per visit	70% after deductible	$20 copay per visit	70% after deductible

LOYOLA PPO MEDICAL INSURANCE OPTIONS CONTINUED

Options	Core		Basic		Plus	
	In-Network (Tier 2)	Out-of-Network	In-Network (Tier 2)	Out-of-Network	In-Network (Tier 2)	Out-of-Network
In-network services that require a flat copayment at the time of service.						
Office Visits	$40 primary care copay per visit; $55 specialist	60% after deductible	$25 primary care copay per visit; $40 specialist	70% after deductible	$20 primary care copay per visit; $35 specialist	70% after deductible
Vision (exam every 24 months)	$40 copay per visit	60% after deductible	$25 copay per visit	70% after deductible	$20 copay per visit	70% after deductible
Maternity (prenatal visits)	$55 copay per pregnancy	60% after deductible	$40 copay per pregnancy	70% after deductible	$35 copay per pregnancy	70% after deductible
Outpatient Substance Abuse	100% after $40 copay	60% after deductible	100% after $25 copay	70% after deductible	100% after $20 copay	70% after deductible
Office Visit Substance Abuse	$40 copay per visit	60% after deductible	$25 copay per visit	70% after deductible	$20 copay per visit	70% after deductible
Physical/ Occupational Therapy	$40 copay per visit	60% after deductible	$25 copay per visit	70% after deductible	$20 copay per visit	70% after deductible
Speech Therapy	$40 copay per visit	60% after deductible	$25 copay per visit	70% after deductible	$20 copay per visit	70% after deductible
X-Ray and Lab (regular diagnostic)	100% covered	60% after deductible	100% covered	70% after deductible	100% covered	70% after deductible
Preventive care screening/ immunization	no charge	not covered	no charge	not covered	no charge	not covered
Out-of-Pocket Limit*	$4,750 per person ($9,500 family limit)	$9,500 per person ($19,000 family limit)	$4,500 per person ($9,000 family limit)	$7,500 per person ($15,000 family limit)	$1,250 per person ($2,500 family limit)	$2,500 per person ($5,000 family limit)

**Amounts that count toward your out-of-pocket limit include: your share of copayments, deductibles and coinsurance.*

You can find additional information about the medical plans by referring to the Summary of Benefits and Coverage (SBC) documents prepared by UnitedHealthcare found on the HR website.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, your deductible and coinsurance apply as according to your employer-sponsored medical insurance plan. If you would like more information on WHCRA benefits, call your plan administrator in the Human Resources office at 504-864-7757.

Ochsner Health Network Benefits

United Healthcare and Ochsner Health Network are working together to provide a patient-centered health plan designed to help promote better health and lower costs. Your current benefits under UHC's ChoicePlus Network are now Tier 2. Providers and facilities within both Tier 1 and Tier 2 are in-network, but you will receive enhanced benefits on covered services when you choose to use an Ochsner provider in Tier 1.

LOYOLA OCHSNER HEALTH NETWORK (TIER 1) BENEFITS			
Options	**Core**	**Basic**	**Plus**
Calendar Year Deductible	**$1,250 Individual $3,750 Family**	**$1,000 Individual $3,000 Family**	**$350 Individual $700 Family**
In-network services that require you to first meet your calendar year deductible before the plan starts paying coinsurance.			
Inpatient Hospital (includes maternity)	**85% after deductible**	**95% after deductible**	**$150 copay per day, for the first 3 days only**
Outpatient Surgery (and Physicians fee)	**85% after deductible**	**95% after deductible**	**100% after deductible**
MRI/PET (major diagnostic) prior authorization required	80% after Tier 2 deductible	80% after Tier 2 deductible	100% after Tier 2 deductible
Ambulance	80% after Tier 2 deductible	80% after Tier 2 deductible	100% after Tier 2 deductible
Inpatient Mental Health	80% after Tier 2 deductible	80% after Tier 2 deductible	$200 copay per day, for the first 3 days only
Inpatient Substance Abuse	80% after Tier 2 deductible	80% after Tier 2 deductible	$200 copay per day, for the first 3 days only
Skilled Nursing Facility (60 days per year)	80% after Tier 2 deductible	80% after Tier 2 deductible	100% after Tier 2 deductible
Home Health Care (60 visits per year)	80% after Tier 2 deductible	80% after Tier 2 deductible	100% after Tier 2 deductible
Urgent Care	$55 copay per visit	$40 copay per visit	$35 copay per visit
Emergency Room (copayment waived if admitted)	$150 copay per visit	$150 copay per visit	$150 copay per visit
Outpatient Mental Health	100% after $40 copay	100% after $25 copay	100% after $20 copay
Office Visit Mental Health	$40 copay per visit	$25 copay per visit	$20 copay per visit
Office Visit	**$30 primary care copay per visit; $45 specialist**	**$20 primary care copay per visit; $30 specialist**	**$15 primary care copay per visit; $25 specialist**
Vision (exam every 24 months)	$30 copay per visit	$25 copay per visit	$20 copay per visit
Maternity (prenatal visits)	$55 copay per pregnancy	$40 copay per pregnancy	$35 copay per pregnancy
Outpatient Substance Abuse	100% after $40 copay	100% after $25 copay	100% after $20 copay
Office Visit Substance Abuse	$40 copay per visit	$25 copay per visit	$20 copay per visit
Physical/Occupational Therapy	$40 copay per visit	$25 copay per visit	$20 copay per visit
Speech Therapy	$40 copay per visit	$25 copay per visit	$20 copay per visit
X-ray and Lab (regular diagnostic)	100% covered	100% covered	100% after Tier 2 deductible
Preventive Care Screening/Immunization	no charge	no charge	no charge
Out-of-Pocket Limit	$4,750 per person ($9,500 family limit)	$4,500 per person ($9,000 family limit)	$1,250 per person ($2,500 family limit)

enhanced benefits on covered services in the Ochsner Health Network (Tier 1) are highlighted and in **bold*