Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

NOTICE OF PLAN CHANGES for 2022
Non-Grandfathered ASO Medical Plans

Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. are committed to improving the health and lives of Louisianians. We are dedicated to this mission and to providing coverage that meets the healthcare needs and budgets of your employees and their families.

The Cross and Shield has more than 85 years of service in our communities and we are working hard to provide you and your employees with the tools and information needed to stay healthy. We take this responsibility seriously and appreciate your confidence in us to deliver the best possible healthcare solutions for your business.

To keep costs under control, improve the quality of care for your employees, and comply with the Affordable Care Act (ACA), we are implementing the benefit changes outlined below for Self-Funded Groups. **These changes will become effective upon your group's anniversary date in 2022.**

Please review all information below and discuss any optional benefit changes with your producer and/or Blue Cross Representative.

Please read this information carefully.

2022 BENEFIT CHANGES	
Change to Prescription Day Supply Limitations at Retail Pharmacies for 2-Tier Prescription Drug Benefits **Only applicable to groups who have pharmacy benefits through Blue Cross or HMO Louisiana administered by ESI**	Members with 2-Tier Prescription Drug Benefits will be able to fill prescriptions for non-specialty drugs for up to a 30-day supply at a retail pharmacy, an 84 to 90-day supply at a retail maintenance pharmacy and up to a 90-day supply at mail order pharmacy, for benefit plans that offer mail order. To verify your plan's pharmacy benefits, please refer to your plan's Schedule of Benefits. Not Applicable to the St. Tammany Parish School System Pharmacy Plan
Exclusion Language for Selected Cost Outlier Prescription Drugs **Only applicable to groups who have pharmacy benefits through Blue Cross or HMO Louisiana administered by ESI**	Selected prescription drug products with multiple therapeutic alternatives, which may be available in a greater or lesser strength or different dosage form (e.g., tablet, capsule, liquid, suspension, extended release, tamper resistant) will not be covered. To find out if a drug is covered, please visit www.bcbsla.com/pharmacy. For groups with an open formulary, if you wish to opt out of this exclusion and provide coverage for selected cost outlier prescription drugs, please contact your Blue Cross Representative. To verify your plan's pharmacy benefits, please refer to your plan's Schedule of Benefits. Not Applicable to the St. Tammany Parish School System Pharmacy Plan

Not Applicable to the St. Tammany Parish School System Plan

Cost of Living Adjustments (COLAs) based on IRS Guidelines

Special rules apply to the amounts for each member within a family

The IRS has released 2022 COLAs. Please refer to the table below. All other deductible and out-of-pocket amounts will remain unchanged.

Affordable Care Act (ACA) Annual Out-of-Pocket (OOP) Maximums for Non-Grandfathered (NGF) Plans			
Plan Type	**Coverage**	**2021**	**2022**
Health Savings Account (HSA)* and Non-HSA Qualified Plans	Individual	$8,550	$ 8,700
Non-HSA Qualified Plans	Family	$17,100	$ 17,400
IRS Out-of-Pocket (OOP) Maximums for HSA-eligible High Deductible Health Plans (Grandfathered & Non-Grandfathered) Applicable to Blue*Saver* and Blue Connect Savings Plus Plans			
Plan Type	**Coverage**	**2021**	**2022**
HSA Qualified Plans	Individual	$7,000	$7,050
HSA Qualified Plans	Family	$14,000	$14,100
IRS Deductible Minimums for HSA-eligible High Deductible Health Plans (Grandfathered & Non-Grandfathered) Applicable to Blue*Saver* and Blue Connect Savings Plus Plans			
Plan Type	**Coverage**	**2021**	**2022**
HSA Plan Type	Individual	$1,400	$1,400
HSA Plan Type	Family	$2,800	$2,800

*For ACA plans, the OOP Maximum Per Member within a Family may not exceed $8,700 in 2022.

If you currently offer an HSA-qualified Blue*Saver* or Blue Connect Savings Plus plan (a qualified high deductible health plan) and would like to change your deductible or max out-of-pocket amounts to remain compliant, please contact your Blue Cross Representative to request changes. **Failure to comply with these IRS guidelines could result in loss of qualified health plan status.**

Additions and Changes to Preventive Services Governed by USPSTF (U.S. Preventive Services Task Force)	The ACA requires preventive and wellness service coverage which mainly results from U.S. Preventive Services Task Force (USPSTF) recommendation levels 'A' and 'B' and less often results from recommendations from the Advisory Committee on Immunization Practices (ACIP) and the Health Resources and Service Administration (HRSA). These preventive and wellness services will be covered at no cost to you when rendered by a Network provider. The services listed below will be added to and/or revised in policies for 2022. Additional services may be added as required by law and may include enhancements to existing services. • Colorectal Cancer (CRC) Screening – Coverage for colorectal cancer screening services is available for adults aged 45 to 75 years. Coverage is available for Cologuard (Stool DNA-FIT) testing once per benefit period for members in this age range. This is an update to the existing mandate. • Counseling for Healthy Weight and Weight Gain in Pregnancy – Coverage is available for pregnant persons for effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy. • Screening for Lung Cancer – Coverage for annual low-dose computed tomography (LDCT) screening is available for adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. This is an update to the existing mandate. • Ervebo Vaccination – Coverage for Ervebo vaccination is available. ACIP recommends preexposure vaccination with Ervebo for adults aged 18 years or older in the U.S. population who are at highest risk for potential occupational exposure to Ebola virus species Zaire ebolavirus because of the following: o responding to an outbreak of Ebola Virus Disease o working as health care personnel at federally designated Ebola treatment centers in the United States, or o working as laboratorians or other staff at biosafety level 4 facilities in the United States.

Changes to Plan Documents Resulting from Federal Consolidated Appropriations Act (CAA), 2021	The Consolidated Appropriations Act (CAA), 2021 contains numerous provisions 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 some CAA provisions. There are other provisions of the CAA that do not impact the plan documents, but that may still impact your health plan. There will be separate communications that will detail the full impact of the CAA. Unless stated otherwise, the following provisions become effective upon issuance or renewal of policies on or after January 1, 2022. • Continuity of Care - Section 113 of the CAA defines a continuing care person entitled to continuing care to include a person who is undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill. The CAA requires health plans to provide notice to continuing care patients of their right to continuity of care and to continue to provide Network coverage for up to 90 days after a provider or facility leaves a network. Providers must accept Network reimbursement during the 90-day period. To comply with this federal law, the following revisions to the benefit plans have been made: o Definition of "Serious Acute Condition" is deleted and replaced with "Serious and Complex Condition". o Current plan provisions on continuity of healthcare services have been revised to conform to federal law. • Non-Emergency Services: Prohibition on Balance Billing - Section 102 of the CAA prohibits balance billing for Non-Emergency Medical Services performed by Non-Network Providers at Network facilities, with certain enumerated exceptions. o Notices of the prohibition on balance billing by such providers have been added to the benefit plans and Schedules of Benefits. • Air Ambulance: Prohibition on Balance Billing - Section 105 of the CAA prohibits balance billing for patients receiving air ambulance services from Non-Network Providers. If the air ambulance services would have been covered if provided by a Network Provider, then the air ambulance services that are provided by a Non-Network Provider are required to be covered at the same cost sharing that applies to a Network Provider. If a health plan does not provide air ambulance benefits, the CAA does not require that air ambulance benefits be provided. o Revisions have been made where necessary to Schedules of Benefits to ensure cost sharing for Non-Network Providers complies with this provision of the CAA. • Emergency Medical Services: Definition Expanded & Non-Network Cost Sharing Prohibited for Non-Network Emergency Medical Services - Section 102 of the CAA expands the definition of Emergency Medical Services beyond services performed in the Emergency department of a hospital and to include additional services provided to a person even after their stabilization. The law requires that Emergency Medical Services be provided without prior authorization, without respect to the providers' Network status, and applying Network cost sharing based on the qualified payment amount (an amount defined in the CAA). o Various revisions to the benefit plans and Schedules of Benefits have been made to revise the definition of Emergency Medical Services, to ensure Network cost sharing is applied, and to remove any language that might be construed to require prior Authorizations of Emergency Medical Services.

Breast MRI Coverage - Act 45 (SB 119)	The Louisiana Legislature enacted Act 45 (SB 119) during the 2021 Regular Session. Act 45 expands minimum mammography coverage requirements and also requires Breast MRIs to be covered with any applicable deductible waived. The expanded coverage for minimum mammography and coverage for Breast MRIs required by Act 45 are set forth below. While high deductible health plans (HDHPs) are not subject to Act 45, HDHP plans may implement coverage set forth in the law. **Current:** Breast MRIs are a covered benefit subject to applicable copayments, deductibles and coinsurance. **2022:** Act 45 requires the following coverage for Breast MRIs. Breast MRIs stated below will ***not*** be subject to applicable deductible. <u>Breast MRI Coverage</u> Age 25+: - Annual Breast MRI for women with hereditary susceptibility or prior chest wall radiation Age 35+: - Annual mammogram and access to supplemental imaging (Breast MRI) upon recommendation of physician for women with >20% predicted lifetime risk Age 40+: - Supplemental imaging (breast ultrasound, then Breast MRI if breast ultrasound is inconclusive) if recommended by physician for women with C and D breast density - Annual Breast MRI if recommended by physician for women with prior history of breast cancer under 50 years of age - Annual Breast MRI if recommended by physician for women with prior history of breast cancer at any age with C and D breast density **NON-ERISA GROUPS ONLY:** Deductibles, if applicable, will be waived to comply with Act 45. **NON-ERISA HDHP GROUPS ONLY:** If you wish to opt out of this enhancement for Breast MRI coverage, please contact your Blue Cross Representative. If applicable, prior authorization will be required.

Minimum Mammography Coverage – Act 45 (SB 119)	The Louisiana Legislature enacted Act 45 (SB 119) during the 2021 Regular Session. Act 45 expands minimum mammography coverage requirements and also requires Breast MRIs to be covered with any applicable deductible waived. The expanded coverage for minimum mammography and coverage for Breast MRIs required by Act 45 are set forth below. While high deductible health plans (HDHPs) are not subject to Act 45, HDHP plans may choose to implement coverage set forth in the law. **STATE LAW EXPANSION OF MINIMUM MAMMOGRAPHY COVERAGE** **Current:** *ASO groups may have customized benefits that exceed the following current minimum mammography coverage.* <u>Mammography Examination, including Breast Ultrasound*</u> Ages 35 – 39: - One (1) Baseline Mammogram Ages 40 – 49: - One (1) exam every twenty-four (24) months or as doctor prescribes Age 50+: - One (1) exam every twelve (12) months *A breast ultrasound may be completed alone or in conjunction with a mammogram. **2022:** Act 45 expanded minimum mammography coverage as follows: <u>Mammography Examination, including Breast Ultrasound*</u> Age 30+: - Annual mammogram (DBT) for women with hereditary susceptibility or prior chest wall radiation Ages 35 – 39: - One (1) Baseline Mammogram Age 35+: - Annual mammogram (DBT) and access to supplemental imaging (Breast MRI) upon recommendation of physician for women with >20% predicted lifetime risk Age 40+: - Annual mammogram (DBT) *and* - Supplemental imaging (breast ultrasound, then Breast MRI if breast ultrasound is inconclusive) if recommended by physician for women with C and D breast density *A breast ultrasound may be completed alone or in conjunction with a mammogram.

Minimum Mammography Coverage – Act 45 (SB 119) **(continued)**	**NON-ERISA GROUPS ONLY:** • If your mammography benefits are designed to only meet current minimum mammography requirements, your benefits will be revised to comply with 2022 minimum mammography coverage requirements in Act 45. • If your mammography benefits exceed 2022 minimum mammography coverage requirements in Act 45, we will not revise your benefits unless otherwise instructed. Any revisions to you benefits would have to comply with 2022 minimum mammography coverage requirements in Act 45.

Please use this Notice of Plan Changes for informational purposes. Optional benefit selections will be captured in Benefit Insight, and a signature will be required acknowledging your requested changes at that time.

As always, your satisfaction is our top priority. Please contact your Blue Cross Representative if you have any questions about the information included in this Notice of Plan Changes. Thank you again for allowing us the opportunity to serve you.

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