Louisiana

PELICAN HRA1000 | 2021

CUSTOMER SERVICE | online: www.bcbsla.com/ogb | by phone: 1-800-392-4089 | by email: ogbhelp@bcbsla.com

01MK5980 R10/20

Louisiana

Dear Valued Member:

Thank you for choosing an Office of Group Benefits (OGB) Plan administered by Blue Cross and Blue Shield of Louisiana. We are proud to serve you and look forward to a long and healthy relationship.

If you are a new member, welcome!

If you are a new or existing member and have not received your ID card, please contact us toll-free at 1-800-392-4089. Be sure to present your ID card any time you need to access medical care or pharmacy services.

We have enclosed information to help you manage your healthcare and health coverage needs. Please review the Schedule of Benefits, Benefit Plan Document and all other enclosures carefully.

- **Schedule of Benefits** - Provides you with important information about covered medical services such as urgent care or inpatient hospital admission, deductibles and out-of-pocket amounts, as well as information on services not covered.
- **Benefit Plan Document** - Provides detailed information about your covered benefits such as medical equipment, ambulance services, pre-existing conditions and information about excluded services.

To find your Louisiana doctor or hospital, visit the Blue Cross OGB website at www.bcbsla.com/ogb, choose your member type and then Find a Doctor. To find a national provider, go to www.bcbsla.com/findcare and choose National Medical. You will also find a wealth of information available on this website, including a members-only section, which is available when you register or login to your online account.

If you have questions about your plan, please call one of our Customer Service advisors toll-free at **1-800-392-4089** or you can email us at **ogbhelp@bcbsla.com.**

Thank you for allowing us to serve you.

Sincerely,

Danielle Conway

Danielle Conway, Vice President
Enrollment and Billing

01MK4857 R10/19

10 things you need to know about your health plan

Welcome!

Please take a few minutes to read this quick guide. It's got great info on getting the most out of your health plan.

1. **Activate Your Account at www.bcbsla.com/Activate**
2. **Get to Know Your Benefits**
3. **Know Who Is in Your Network and How to Get Care**
4. **Get Care in the Best Setting**
5. **Your Member ID Card**
6. **Understand Your Explanation of Benefits**
7. **Take Charge of Your Own Health**
8. **Use Our Mobile and Online Tools**
9. **Understand Health Plan Terms**
10. **Know Whom to Call**

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1 Activate Your Account at www.bcbsla.com/Activate

Your online account gives you the facts you need to get the most out of your health plan. Here are a few things you'll be able to do:

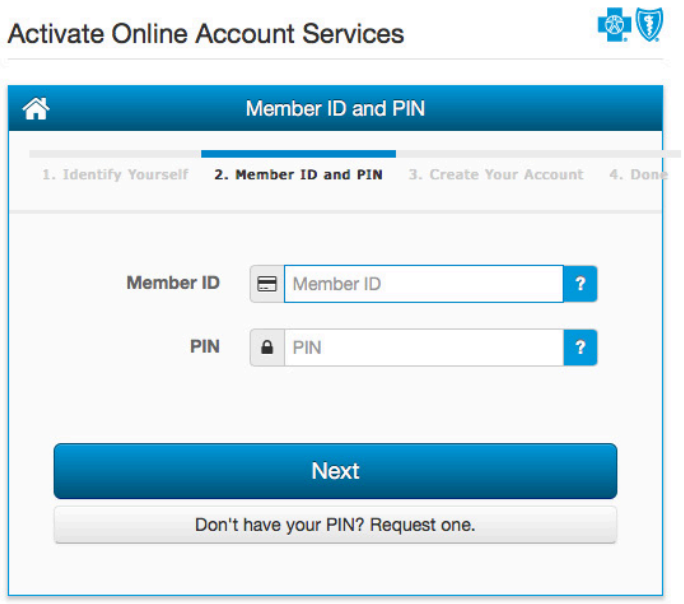
- Get the **details on your health plan costs**, like how much of your deductible has been met.
- See a list of your **most recent claims** or look up older claims.
- Learn all about **Live Better Louisiana: Our Game Plan for Better Health**—your exclusive free wellness program.
- Get wellness discounts through **Blue365®** — they're worth a lot!
- Check out **discount dental solutions** just for you from Blue365®.
- Find **tips for getting healthy** and staying well.

You have to register first, so go to www.bcbsla.com/Activate today!

You'll need to have your member ID card handy when you register.

Need Help?

If you have trouble activating your account or need to get a PIN (personal identification number), call 1-800-821-2753, 8 a.m. - 5 p.m., Mon-Fri. Automated PIN support is available after hours.



2 Get to Know Your Benefits

Because we offer many plans, it's a good idea to know what your own plan covers.

These details are in your benefit plan and your Schedule of Benefits. If you still have questions about coverage, please call Customer Service at 1-800-392-4089 or email us at OGBhelp@bcbsla.com.

Keep These Items Handy

1. **Member ID Card** – This personalized card has your (or your family's, if it applies) unique contract number on it. Please carry it with you. Your doctor or the hospital will want to see it before they serve you. Your ID card will be mailed to you apart from your benefit plan.
2. **Benefit Plan** – This document spells out your benefits and coverage. It includes what is covered and what is not, and any dollar limits that may apply.
3. **Schedule of Benefits** – This is a specific list of services and supplies and what you can expect to pay for them, like any copayments, deductibles and coinsurance you may have.

Things to Know for Any Plan

- **Using network healthcare providers is always best.** To avoid unexpected costs, use a network provider. If you're not sure who's in your network, check our directory at **www.bcbsla.com/OGB** (choose your member type and then Find a Doctor) or call Customer Service at 1-800-392-4089.
- **Check if you need approval or authorization.** Some services require authorization from us before you receive them. Your benefit plan or Schedule of Benefits has a list of what these services are for your own plan. Note that an authorization is not a guarantee of payment.
- **Know what's covered.** Some plans have exclusions or limitations for services that are not covered. See your benefit plan for more information.

3 Know Who Is in Your Network

Use a network provider to get the most out of your benefits.

Your plan's network doctors, hospitals and other healthcare professionals have agreed to give you the care you need at the best price.

To find which **doctors**, **hospitals**, **hospital-based doctors**, **urgent care centers** and **more** are in your network, just go to **www.bcbsla.com/OGB**, choose your plan type and then **Find a Doctor**.

Use the Online Directory to:

- Compare doctors. See which hospitals they use, other languages they may speak and any certifications they have. You can read any patient reviews submitted and see if your doctor participates in our Quality Blue program.
- Compare hospitals. See awards and patient survey results.
- See on a map where your doctor's office is located.
- Find out if a network hospital's anesthesiologists, ER doctors, neonatologists, pathologists, radiologists or other hospital-based providers are also in your network.
- Find a doctor while you are traveling.
- Find labs that are in your plan's network.

Know How to Get Care in Your Network

Network doctors, hospitals and other healthcare providers have agreed to give you the care you need at the best price.

To find which doctors, hospitals, hospital-based doctors, urgent care centers and more are in your network, just go to **www.bcbsla.com/OGB**, choose your plan type and then **Find a Doctor**.

Network

Here's what you can expect when you see a doctor or go to a hospital that is in your network:

- You get the highest level of benefits your health plan has to offer.
- You save money, because the provider and your health plan have agreed on a discounted rate.
- You won't be billed for the difference between what we pay (together with your cost-sharing amounts) and what the provider charges for covered services.
- You will be responsible for your coinsurance, copayments and deductible that apply with your plan. These are your cost-sharing amounts.

Out-of-Network

Here's what you can expect if you see a doctor or go to a hospital that is **not** in your network:

- You could pay a higher copayment, deductible and coinsurance.
- In addition to your cost-sharing amounts, the doctor or hospital could bill you for the difference between what we pay and what they charge.
- You could get a penalty or reduction in benefits, depending on your plan.

Hospital-based Doctors

Hospital-based providers can include **anesthesiologists**, **emergency room doctors**, **neonatologists**, **pathologists, radiologists** and **other doctors.**. Even if your hospital is in your plan's network, some of your doctors ***may not be***. If these doctors are not in your network, they can bill you for the difference between what they charge and what your plan pays for their services. This means you could pay more.

If you are planning a hospital stay, check out the list of hospital-based doctors at **www.bcbsla.com**. Choose **Find a Doctor**. Under **Hospital Based Physicians**, click **ER/OR Information** to learn more about this situation and see lists of in- and out-of-network physicians based in network hospitals.

Emergency Situations

In the case of a true emergency, seek help at the nearest healthcare facility regardless of network. See the section #4 of this booklet for what an "emergency medical condition" means.

4 Get Care in the Best Setting

General and Specialist Care

If you need care, call your doctor and plan an office visit.

Blue Care

You can also try BlueCare, which lets you reach a doctor online at any time of day or night. Learn more at **www.bluecarela.com**.

Urgent Care

If you can't reach your doctor, urgent care or after-hours clinics are great alternatives to the emergency room when you do not have a true emergency.

Emergencies

Call 911 or go to the nearest emergency room.

An emergency medical condition, as defined by state law, is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: 1) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; 2) Serious impairment to bodily function; 3) Serious dysfunction of any bodily organ or part.

Lab Work

If your doctor doesn't do lab tests in-house, ask the staff to send you *or your samples* to a network lab or one of our statewide, full-service labs.

Imaging Tests

If your doctors don't or can't perform tests like CT or MRI scans in their offices, ask them to send you to a network imaging clinic.

Don't forget! You will need your member ID card for all healthcare services.

5 Your Member ID Card

Your ID card includes the following:

- Your member number
- Your physician and specialist copayment amounts or deductible/coinsurance
- Customer Service and authorization telephone numbers
- Prescription drug information

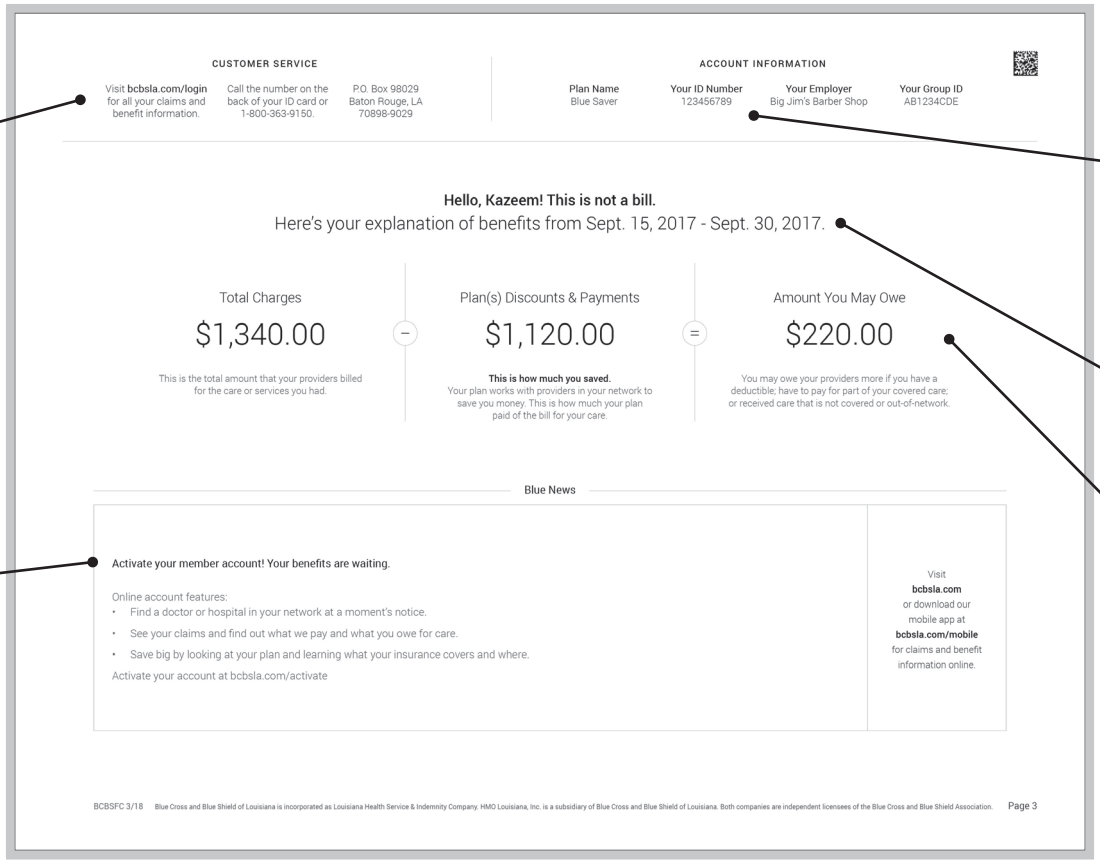
Please remember to carry your ID card with you at all times for instant recognition from your providers.

If you lose your ID card, please call our Customer Service Department at **1-800-392-4089** for a new ID card or email us at OGBhelp@bcbsla.com.

6 Understand Your Explanation of Benefits

Your Explanation of Benefits (EOB) quickly, easily, and clearly describes benefits, costs, discounts and more. An EOB form is a snapshot of claims and cost for care. It shows what we paid for care and what you may expect to pay out of pocket.

Your EOB has important information. Claims codes are explained in clearer language than in years' past. Your deductible amount, if applicable, and other amounts that change during the year are clearly shown.



CUSTOMER SERVICE

Visit **bcbsla.com/login** for all your claims and benefit information.

Call the number on the back of your ID card or 1-800-363-9150.

P.O. Box 98029
Baton Rouge, LA
70898-9029

ACCOUNT INFORMATION

Plan Name	Your ID Number	Your Employer	Your Group ID
Blue Saver	123456789	Big Jim's Barber Shop	AB1234CDE

Hello, Kazeem! This is not a bill.
Here's your explanation of benefits from Sept. 15, 2017 - Sept. 30, 2017.

Total Charges		Plan(s) Discounts & Payments		Amount You May Owe
$1,340.00	−	$1,120.00	=	$220.00
This is the total amount that your providers billed for the care or services you had.		**This is how much you saved.** Your plan works with providers in your network to save you money. This is how much your plan paid of the bill for your care.		You may owe your providers more if you have a deductible; have to pay for part of your covered care; or received care that is not covered or out-of-network.

Blue News

Activate your member account! Your benefits are waiting.

Online account features:
- Find a doctor or hospital in your network at a moment's notice.
- See your claims and find out what we pay and what you owe for care.
- Save big by looking at your plan and learning what your insurance covers and where.

Activate your account at bcbsla.com/activate

Visit **bcbsla.com** or download our mobile app at **bcbsla.com/mobile** for claims and benefit information online.

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How to reach Blue Cross if you have questions.

Page 3

Your member ID number and other key information.

Date range this EOB covers.

Your financial responsibility.

Important news from Blue Cross.

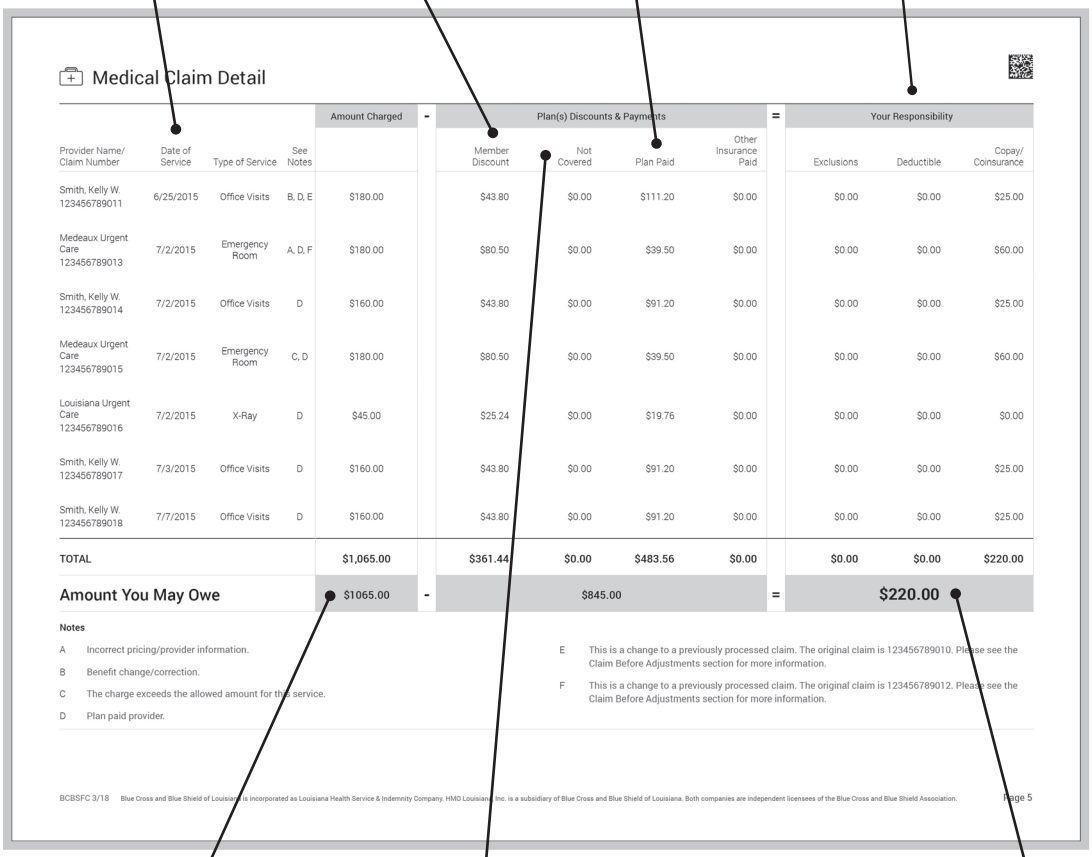
The date you received medical services.

The amount you saved by seeing an in-network healthcare provider.

The amount your health plans paid, split into Provider, You and Other Insurance Paid.

Your share, split into Exclusions (not covered by your health plan), Deductible and Copayment/ Coinsurance.

Page 5



Medical Claim Detail

Provider Name/ Claim Number	Date of Service	Type of Service	See Notes	Amount Charged	- Plan(s) Discounts & Payments: Member Discount	Not Covered	Plan Paid	Other Insurance Paid	= Your Responsibility: Exclusions	Deductible	Copay/ Coinsurance
Smith, Kelly W. 123456789011	6/25/2015	Office Visits	B, D, E	$180.00	$43.80	$0.00	$111.20	$0.00	$0.00	$0.00	$25.00
Medeaux Urgent Care 123456789013	7/2/2015	Emergency Room	A, D, F	$180.00	$80.50	$0.00	$39.50	$0.00	$0.00	$0.00	$60.00
Smith, Kelly W. 123456789014	7/2/2015	Office Visits	D	$160.00	$43.80	$0.00	$91.20	$0.00	$0.00	$0.00	$25.00
Medeaux Urgent Care 123456789015	7/2/2015	Emergency Room	C, D	$180.00	$80.50	$0.00	$39.50	$0.00	$0.00	$0.00	$60.00
Louisiana Urgent Care 123456789016	7/2/2015	X-Ray	D	$45.00	$25.24	$0.00	$19.76	$0.00	$0.00	$0.00	$0.00
Smith, Kelly W. 123456789017	7/3/2015	Office Visits	D	$160.00	$43.80	$0.00	$91.20	$0.00	$0.00	$0.00	$25.00
Smith, Kelly W. 123456789018	7/7/2015	Office Visits	D	$160.00	$43.80	$0.00	$91.20	$0.00	$0.00	$0.00	$25.00
TOTAL				$1,065.00	$361.44	$0.00	$483.56	$0.00	$0.00	$0.00	$220.00
Amount You May Owe				$1065.00	- $845.00				= $220.00		

Notes

A Incorrect pricing/provider information.

B Benefit change/correction.

C The charge exceeds the allowed amount for this service.

D Plan paid provider.

E This is a change to a previously processed claim. The original claim is 123456789010. Please see the Claim Before Adjustments section for more information.

F This is a change to a previously processed claim. The original claim is 123456789012. Please see the Claim Before Adjustments section for more information.

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Total amount charged by a healthcare provider.

Any portion of the submitted charges not payable based on current information. The reason will be explained.

Amount you owe providers. You may have already paid some or all of these charges.

Go Paperless

You can also see your EOB by logging in to your account at www.bcbsla.com/OGB. Under My Account, click **Manage Your Account** then **View Your Statements**.

You can choose to go paperless and Blue Cross will notify you via email when you have new EOBs and other important documents. Log into your account at www.bcbsla.com/OGB and select **Go Paperless**. Under **Communication Preference**, select **yes** and make sure we have the email address where you want to receive notifications. You can request paper copies of certain documents or request that all documents be sent in paper form at any time.

7 Take Charge of Your Own Health

Take advantage of **Live Better Louisiana**—a free wellness program for Blue Cross plan members, both active employees and retirees. Live Better Louisiana is OGB's game plan for better health. Sponsored by Blue Cross and Blue Shield of Louisiana at no extra charge to OGB members, the program can help you make educated choices, keep from getting sick and manage any conditions that do appear.

And, those members who take full advantage of the program are eligible for a premium credit of at least $120 in 2022.* *So how do you take part?*

Schedule Your Preventive Health Checkup

Blue Cross works with an industry leader, Catapult Health, to bring preventive checkups to **a site near you**. You can schedule a free checkup with a licensed nurse practitioner and health technician through the online scheduler. You'll get **lab-accurate diagnostic tests** and receive a full **Personal Health Report** with checkup results and recommendations.

Schedule your appointment online at **www.TimeConfirm.com/OGB** or call **1-877-841-3058**. Complete your clinic appointment to get the credit. If you are not able to go to a clinic, have your doctor fax a completed Primary Care Provider form, found at **www.bcbsla.com/PCPform**, to Catapult Health. Do this by Aug. 31, 2021, to earn your premium credit. Any changes to deadlines or requirements will be publicized.

Take Charge of Your Own Health with a Wealth of Resources

Live Better Louisiana gives you access to a wide range of **healthy activities** and wellness-related **deals and discounts**.

How do you get there? Explore the Save and Wellness menus at **www.bcbsla.com/OGB**.

If you got a premium credit for a prior year, you will need to earn it again for 2022. Remember, to participate in the Live Better Louisiana program and get a Catapult check-up, you must be the primary member on a 2021 OGB Blue Cross plan at the time of the check-up.* ***In order to receive the credit, you must be enrolled in an OGB Blue Cross plan as the primary member in 2022.*

Manage Long-term Health Conditions

Your health is important to us. Our health coaches want to support you in leading a fuller, healthier life. If you have been diagnosed with a serious or long-term health condition, our in-house team of doctors, nurses, social workers, dietitians and pharmacists offers health coaching, prescription incentives, educational materials and caring support.

As an OGB plan member, you are automatically enrolled in Population Health Management if you:

- Are enrolled in one of the Blue Cross health plans;
- Do not have Medicare as primary health coverage; and,
- Have been diagnosed with one or more of these ongoing health conditions: diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD).

This program could help you save money on your prescriptions. Copayments for select drugs prescribed for treating diabetes, coronary artery disease, heart failure, asthma and COPD are discounted when you participate in Blue Health Services.

Ready to join? Simply call our toll-free number at **1-800-363-9159** and speak with one of our health coaches to get started.

Quit Smoking

Quitting can be easier with free, confidential support. The Louisiana Tobacco Quitline can help! Call **1-800-QUIT-NOW** or enroll for free at **www.quitwithusla.org**. Choose phone counseling, web support or both to develop a quit plan that works for you.

Prevent Type 2 Diabetes

OGB is offering eligible employees and their dependents over age 18 a new 16-week online program called **Omada**, designed to help participants **lose weight and reduce your risk of developing type 2 diabetes**. Employees and adult dependents who meet the criteria receive a personal health coach, a wireless scale and pedometer, weekly online lessons and more. Visit **omadahealth.com/OGB** to learn the criteria and to sign up, if eligible.

Omada is a program of Omada Health, an independent company that provides a diabetes prevention program to OGB members.

Get Exclusive Discounts and Deals

Blue Cross brings OGB members free deals on select health and wellness products and services through **Blue365®**. Discount offers include:

- Exclusive low-cost membership to 10,000+ gyms nationwide (with three-month commitment)
- 15% - 35% off of namebrand fitness gear and wearable technology.
- 10-40% off Davis Vision products
- Discounts on hearing aids
- Discounts of 20-50% to a network of dentists

Find out more at **www.Blue365Deals.com/bcbsla**.

8 Use Our Mobile and Online Tools

Blue Cross offers a wide range of online tools, social media accounts and a mobile app for those members who like to get their information while on the go. Activate or log in to your account at **www.bcbsla.com/OGB** to access any of these tools.

Mobile App: Find a doctor or urgent care, view your claims, benefits and even search your symptoms to see a suggested diagnosis—all on your mobile device, thanks to our mobile-friendly website and our mobile app for both iOS and Android. Download the BCBSLA Mobile App from your App Store or Google Play today!

See a Doctor Online: BlueCare lets you see a doctor anytime, anywhere, so you can get care outside of doctors' office hours or during the workday without leaving home, work or school. BlueCare is faster and less expensive than going to urgent care or the ER for minor health needs. No appointment is needed, and BlueCare is available on a computer, tablet or smartphone. Learn more at **www.BlueCareLA.com**.

Social Hub: If you follow Facebook or Twitter, check out Blue Cross' accounts on those services and many others. At **www.bcbsla.com/social**, you can access all of our social accounts for wellness tips, recipes, breaking health news and more—as well as a sense of community.

Compare Costs to Save on Services: Our new SmartShopper tool lets you compare the costs of common medical procedures based on price and location. With these facts, you can make the choice that's right for you. Have your member ID ready and visit **bcbsla.vitalssmartshopper.com**.

Personal Health Assessment: The Personal Health Assessment (PHA) is an online questionnaire that allows you to learn any health risks you might face and prioritize an action plan to address them. Log in to your account and choose **Wellness**, then click **Tools** to access your PHA.

Health Education: Visit our extensive online Wellness Library, watch educational and entertaining videos on health topics, check the latest medical guidelines for specific ages and gender and read Health Condition Guides on common illnesses and injuries. Also take advantage of multimedia self-care workbooks on asthma, diabetes, COPD, heart disease and heart failure that will help you learn more about living well with these conditions.

9 Understand Health Plan Terms

Health insurance can be confusing. If you have trouble understanding a word you see in your benefit plan, on your Explanation of Benefits or on your bill, contact us through our secure online form on **www.bcbsla.com/OGB** or call our Customer Service Department at **1-800-392-4089**.

10 Know Whom to Call

Our Customer Service team—located in Louisiana—can answer a wide range of questions from members across the country. You can also find answers under *Services & Support*, linked at the bottom of our website at **www.bcbsla.com/OGB**.

Customer Service	For benefits, claims, and other service issues, call **1-800-392-4089**, 8 a.m. - 8 p.m., Monday - Friday, except holidays, or call the number on your ID card. Email **OGBhelp@bcbsla.com** (This email address is not secure for your personal health information. To send a secure message, use the secure Online Contact Form found under *Contact Us* at **www.bcbsla.com/OGB**.)
Secure Online Email	Your personal health information is safe and secure when you contact us through our Secure Online Contact Form. Go to *Contact Us* at the bottom of any page and select Customer Service for details.
Hearing Impaired	**1-800-846-5277**
TTY (Text Telephone) Callers or TTD	Call Louisiana Relay Service (LRS) for help by dialing 771 for quick access or **1-888-699-6869**. Give LRS the Blue Cross toll-free number, **1-800-495-2583**, to direct your call.
Online Account Helpline	Login, Registration, PIN and Password Support: 1-800-821-2753, 8 a.m. - 5 p.m., Mon-Fri. Automated PIN support is available after hours.
Authorizations (non-urgent)	**1-800-523-6435**, 8:30 a.m. – 4 p.m., Monday – Friday
When receiving healthcare services outside of Louisiana	**Blue Card Program Service Center** & Doctor and Hospital Finder at **www.bcbs.com**, **1-800-810-BLUE (2583)**, 24 hours, seven days a week; Only emergency services are available to Magnolia Local members when out of state.
Pharmacy Customer Service	Call the pharmacy number on the back of your member ID card.
Send Claims to:	**Blue Cross and Blue Shield of Louisiana** Claims Processing P.O. Box 98029 Baton Rouge, LA 70898-9029

Louisiana

Louisiana

Section I

Schedule of Benefits

Louisiana

OGB
PELICAN HRA 1000

COMPREHENSIVE CDHP MEDICAL BENEFIT PLAN
SCHEDULE OF BENEFITS

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

BENEFIT PLAN FORM NUMBER 40HR2031 R01/21

PLAN NAME	PLAN NUMBER
State of Louisiana Office of Group Benefits	ST222ERC
PLAN'S ORIGINAL EFFECTIVE DATE	PLAN'S ANNIVERSARY DATE
January 1, 2013	January 1st

Lifetime Maximum Benefit:……..**Unlimited**

Benefit Period: .....01/01/2021 – 12/31/2021

DEDUCTIBLE AMOUNT PER BENEFIT PERIOD

Network Providers -	
Individual	$2,000.00
Family	$4,000.00
Non-Network Providers -	
Individual	$4,000.00
Family	$8,000.00

SPECIAL NOTES

Deductible Amount

Eligible Expenses for services of a Network Provider that apply to the Deductible Amount for Network Providers **will not** accrue to the Deductible Amount for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Deductible Amounts for Non-Network Providers **will not** accrue to the Deductible Amount for Network Providers.

COINSURANCE	Plan	Plan Participant
Network Providers.....	80%	20%
Non-Network Providers.....	60%	40%

OUT-OF-POCKET AMOUNT PER BENEFIT PERIOD
(Includes all eligible Medical and Pharmacy Coinsurance Amounts, Deductibles and/or Copayments)

Network Providers -

Individual	$5,000.00
Family	$10,000.00
Per Member Within a Family	$6,850.00

Non-Network Providers -

Individual	$10,000
Family	$20,000

SPECIAL NOTES

Out-of-Pocket Amount

Eligible Expenses for services of a Network Provider that apply to the Out-of-Pocket Amount for Network Providers **will not** accrue to the Out-of-Pocket Amount for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Amount for Non-Network Providers **will not** accrue to the Out-of-Pocket Amount for Network Providers.

When the maximum Out-of-Pocket amounts, as shown above have been satisfied, this Plan will pay 100% of the Allowable Charge toward Eligible Expenses for the remainder of the Plan Year.

*If this Benefit Plan includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and Per Member within a Family Out-of-Pocket Amount applies.

There may be a significant Out-of-Pocket expense to the Plan Participant when using a Non-Network Provider.

Eligible Expenses

Eligible Expenses are reimbursed in accordance with a fee schedule of maximum Allowable Charges; not billed charges.

All Eligible Expenses are determined in accordance with plan Limitations and Exclusions.

Eligibility

The Plan Administrator assigns Eligibility for all Plan Participants.

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics • Geriatrics	80% - 20%[1]		60% - 40%[1]
Allied Health/Other Office Visits: • Chiropractor • Retail Health Clinic • Nurse Practitioner • Physician Assistant	80% - 20%[1]		60% - 40%[1]
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietitian • Sleep Disorder Clinic	80% - 20%[1]		60% - 40%[1]
Ambulance Services - Ground	80% - 20%[1]		80% - 20%[1]
Ambulance Services – Air Non-emergency requires prior authorization[2]	80% - 20%[1]		80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20%[1]		60% - 40%[1]
Birth Control Devices - Insertion and Removal (*As listed in the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%		60% - 40%[1]
Cardiac Rehabilitation (*Must begin within six (6) months of qualifying event; Limit of 36 Visits per Plan Year*)	80% - 20%[1,2,3]		60% - 40%[1,2,3]
Chemotherapy/Radiation Therapy	80% - 20%[1]		60% - 40%[1]
Diabetes Treatment	80% - 20%[1]		60% - 40%[1]

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required, if applicable.
Not Applicable for Medicare Primary
[3]Age and/or time restrictions apply

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	80% - 20%[1]		Not Covered
Dialysis	80% - 20%[1]		60% - 40%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2]		60% - 40%[1,2]
Emergency Room (*Facility Charge*)	80% - 20%[1]		80% - 20%[1]
Emergency Medical Services (*Non-Facility Charge*)	80% - 20%[1]		80% - 20%[1]
Eyeglass frames and One pair of Eyeglass Lenses or One Pair of Contact Lenses (*Purchased within six (6) months following cataract surgery*)	Eyeglass Frames - Limited to a Maximum Benefit of $50.00[1,3]		Not Covered
Flu Shots and H1N1 vaccines (*Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%		100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*)	80% - 20%[1,3]		Not Covered
High-Tech Imaging – Outpatient (*CT Scans, MRI/MRA, Nuclear Cardiology, PET Scans*)	80% - 20%[1,2]		60% - 40%[1,2]
Home Health Care (*Limit of 60 Visits per Plan Year, combination of Network and Non-Network) (One Visit = 4 hours*)	80% - 20%[1,2]		60% - 40%[1,2]
Hospice Care (*Limit of 180 Days per Plan Year, combination of Network and Non-Network*)	80% - 20%[1,2]		60% - 40%[1,2]
Injections Received in a Physician's Office (*When no other health services is received*)	80% - 20%[1]		60% - 40%[1]
Inpatient Hospital Admission (*All Inpatient Hospital services included*)	80% - 20%[1,2]		60% - 40%[1,2]
Inpatient and Outpatient Professional Services	80% - 20%[1]		60% - 40%[1]
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%		100% - 0%

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required, if applicable.
Not Applicable for Medicare Primary
[3]Age and/or time restrictions apply

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Mastectomy Bras - Ortho-Mammary Surgical (*Limited to three (3) per Plan Year*)	80% - 20%[1]		60% - 40%[1]
Mental Health/Substance Use Disorder - Inpatient Treatment and Intensive Outpatient Programs	80% - 20%[1,2]		60% - 40%[1,2]
Mental Health/Substance Use Disorder- Office Visits and Outpatient Treatment (Other than Intensive Outpatient Programs)	80% - 20%[1]		60% - 40%[1]
Newborn – Sick, Services excluding Facility	80% - 20%[1]		60% - 40%[1]
Newborn – Sick, Facility	80% - 20%[1,2]		60% - 40%[1,2]
Oral Surgery	80% - 20%[1,2]		60% - 40%[1,2]
Pregnancy Care – Physician Services	80% - 20%[1]		60% - 40%[1]
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan*.)	100% - 0%[3]		100% - 0%[3]
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational [2] (*Limit of 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.*) (*Visit limits are combination of Network and Non-Network Benefits*; *Visit limits do not apply when services are provided for Autism Spectrum Disorders.*)	80% - 20%[1]		60% - 40%[1]
Skilled Nursing Facility (*Limit of 90 days per Plan Year*)	80% - 20%[1,2]		60% - 40%[1,2]
Sonograms and Ultrasounds - Outpatient	80% - 20%[1]		60% - 40%[1]
Urgent Care Center	80% - 20%[1]		60% - 40%[1]

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required, if applicable.
Not Applicable for Medicare Primary
[3]Age and/or time restrictions apply

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Vision Care (Non-Routine) Exam	80% - 20%[1]		60% - 40%[1]
X-Ray (Low-Tech Imaging) and Laboratory Services	80% - 20%[1]		60% - 40%[1]

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required, if applicable.
Not Applicable for Medicare Primary
[3]Age and/or time restrictions apply

ORGAN AND BONE MARROW TRANSPLANTS

Authorization is Required Prior to Services Being Performed

Organ and Bone Marrow Transplants and evaluation for a Plan Participant's suitability for Organ and Bone Marrow transplants will not be covered unless a Plan Participant obtains written authorization from the Claims Administrator, prior to services being rendered.

Network Benefits……..80% - 20%
Non-Network Benefits ……Not Covered

CARE MANAGEMENT

Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, the Plan will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary.

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Plan Participant must pay all charges incurred.

If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the Network status of the Provider rendering the services as shown below.

Authorization of Inpatient and Emergency Admissions

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information.

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with the other Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Deductible and Coinsurance percentage.

If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce the Coinsurance to **50% - 50%**. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance.

The following Admissions require Authorization prior to the services being rendered or supplies being received.

- Inpatient Hospital Admissions (Except routine maternity stays)
- Inpatient Mental Health and Substance Use Disorder Admissions
- Inpatient Organ, Tissue and Bone Marrow Transplant Services
- Inpatient Skilled Nursing Facility Services

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands with a BlueCard® Worldwide Provider are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands from a non-BlueCard® Worldwide Provider **are covered at the Non-Network Benefit level.**

Authorization of Outpatient Services and Supplies

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable unless the procedure is deemed Medically Necessary. If the procedure is deemed Medically Necessary, the Plan Participant remains responsible for his applicable Deductible and Coinsurance percentage. If the procedure is not deemed Medically Necessary, the Plan Participant is responsible for all charges incurred.

If a Non-Network Provider fails to obtain a required Authorization, Benefits are reduced to **50% - 50%** Coinsurance. The Plan Participant is responsible for all charges not covered and remains responsible for his Deductible and Coinsurance.

The following list of Outpatient services and supplies require Authorization prior to the services being rendered or supplies being received.

- Air Ambulance – Non-Emergency (no Benefit without prior Authorization)
- Applied Behavior Analysis
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (Shoulder & Knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300.00)
- Electric & Custom Wheelchairs
- Gene Therapy
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (including but not limited to defibrillators)
- Infusion Therapy – includes home and facility administration (exception: Physician’s office, unless the drug to be infused may require authorization)
- Insulin Pumps
- Intensive Outpatient Programs
- Interventional Spine Pain Management*
- Joint Replacement (Hip, Knee, & Shoulder)*

- Low Protein Food Products
- MRI/MRA
- Meniscal Allograft Transplantation of the Knee*
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician's office)
- Orthotic Devices (greater than $300.00)
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions (such as Coronary Stents and Balloon Angioplasty)*
- PET Scans
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300.00)
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers
- Resting Transthoracic Echocardiography*
- Sleep Studies, (except those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

*Part of the MSK (Pain, Spine, Joint), Radiation Oncology and Cardiac Programs

Population Health – In Health: Blue Health

The Population Health program targets populations with one or more chronic health conditions. The current chronic health conditions identified by OGB are diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). OGB may supplement or amend the list of chronic health conditions covered under this program at any time. (The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.)

Through the In Health: Blue Health Services program, OGB offers an incentive to Plan Participants on Prescription Drugs used to treat the chronic conditions listed above.

a. OGB Plan Participants participating in the program qualify for $0 Copayment for certain Generic Prescription Drugs approved by the U. S. Food and Drug Administration (FDA) for any of the listed chronic health conditions.

b. OGB Plan Participants participating in the program qualify for $15.00 Copayment for certain Brand-Name Prescription Drugs for which an FDA-approved Generic version is not available.

c. If a Generic is available and the OGB Plan Participant chooses the Brand-Name Drug, the OGB Plan Participant pays the difference between the Brand-Name and Generic cost plus the $15.00 Brand-Name Copayment.

The In Health: Blue Health Services prescription incentive does not apply to any Prescription Drugs not used to treat one of the listed health conditions with which you have been diagnosed. Please refer to the Care Management article, Population Health – In Health: Blue Health section of the Benefit Plan for complete information on how to qualify for this incentive.

PRESCRIPTION DRUGS

Prescription Drug Benefits are provided under the Hospital Benefits and Medical and Surgical Benefits Articles of the medical plan, and under the pharmacy benefit programprovided by OGB's Pharmacy Benefits Manager (sometimes "PBM").

Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana provides Claims Administration services **only** for Prescription Drugs dispensed as follows:

Prescription Drugs Covered Under Hospital Benefits and Medical and Surgical Benefits

1. Prescription Drugs dispensed during an Inpatient or Outpatient Hospital stay, or in an Ambulatory Surgical Center are payable under the Hospital Benefits.

2. Medically necessary/non-investigational Prescription Drugs requiring parenteral administration in a Physician's Office are payable under the Medical and Surgical Benefits.

3. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician's office are payable under the Medical and Surgical Benefits.

Authorizations

The following Prescription Drug categories require Prior Authorization. The Plan Participant's Physician must call 1-800-842-2015 to obtain Authorization. The Plan Participant or his Physician should call the Customer Service number on the back of the ID card, or go to the Claims Administrator's website at www.bcbsla.com/ogb for the most current list of Prescription Drugs that require Prior Authorization:

- Growth hormones*
- Anti-tumor necrosis factor drugs*
- Intravenous immune globulins*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*

* Shall include all drugs that are in this category.

Therapeutic/Treatment Vaccines – Examples include, but are not limited to vaccines to treat the following conditions:

- Allergic Rhinitis
- Alzheimer's Disease
- Cancers
- Multiple Sclerosis

Therapeutic/Treatment Vaccines

Network Provider: ..... 100% - 0%

Non-Network Provider: ..... 70% - 30% (After Deductible is Met)

OGB'S Pharmacy Benefits Manager

MedImpact Formulary: 3-Tier Plan Design

OGB's Pharmacy Benefit Manager for the 2021 Plan year is MedImpact. OGB will use the MedImpact Formulary to help Plan Participants select the most appropriate, lowest-cost options. The Formulary is reviewed on at least a quarterly basis to re-assess drug tiers based on the current prescription drug market. Plan Participants will continue to pay a portion of the cost of their prescriptions in the form of a copayment or coinsurance. The amount Plan Participants pay toward their prescription depends on whether they receive a generic, preferred brand or non-preferred brand name drug. You must use drugs on the Formulary to qualify for pharmacy benefits under the Plan.

PRESCRIPTION DRUG	PLAN PARTICIPANT PAYS
Generic	50% up to $30.00
Preferred	50% up to $55.00
Non-Preferred	65% up to $80.00
Specialty	50% up to $80.00
The pharmacy out-of-pocket threshold is $1,500.00. Once met:	
Generic	$0 co-pay
Preferred	$20.00 co-pay
Non-Preferred	$40.00 co-pay
Specialty	$40.00 co-pay

There may be more than one drug available to treat your condition. We encourage you to speak with your Physician regularly about which drugs meet your needs at the lowest cost to you.

For more information on the pharmacy benefit, visit the MedImpact website at **https://mp.medimpact.com/ogb** or **www.groupbenefits.org** or call MedImpact member services at 1-800-910-1831.

Section II

Benefit Plan

Office of Group Benefits
Pelican HRA 1000
For
State of Louisiana Plan Participants

provided by

Louisiana

5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802
www.bcbsla.com

40HR2031 R01/21

NON-GRANDFATHERED

HEALTH BENEFIT PLAN

NOTICES

Healthcare services may be provided to You at a Network healthcare facility by facility-based physicians who are not in Your health plan's Network. You may be responsible for payment of all or part of the fees for those Non-Network services, in addition to applicable amounts due for Copayments, Coinsurance, Deductibles and Non-Covered Services.

Specific information about Network and Non-Network facility-based physicians can be found at **www.bcbsla.com/ogb** or by calling the customer service telephone number on the back of Your identification (ID) card.

The Claims Administrator bases the payment of Benefits for the Plan Participant's Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom You receive Covered Services.

Breast reconstruction is covered for a Plan Participant who due to breast cancer obtains a partial mastectomy or a full unilateral or bilateral mastectomy as selected by the Plan Participant in consultation with the attending Physician(s). The services under this Benefit are subject to any Copayment Amount, Deductible Amount and Coinsurance percentage.

Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. Plan Participants eligible for screenings are those who:

A. were previously diagnosed with breast cancer;
B. completed treatment for breast cancer;
C. underwent bilateral mastectomy; and
D. were subsequently determined to be clear of cancer.

These Covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with the attending Physician and the Plan Participant. Annual preventive cancer screenings under this Benefit will be subject to any Copayment Amount, Deductible Amount and Coinsurance percentage.

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. Claims Administrator does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Important information regarding this Plan will be sent to the mailing address provided for a Plan Participant on their Employee Enrollment / Change Form. Plan Participants are responsible for keeping the Claims Administrator and the Group informed of any changes in their address of record.

I. Steven Udvarhelyi, M. D.
President and Chief Executive Officer

PELICAN HRA 1000 CDHP

TABLE OF CONTENTS

ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

As of the Benefit Plan Date shown in the Plan's Schedule of Benefits, the Plan agrees to provide the Benefits specified herein for Plan Participants of the Plan. This Benefit Plan replaces any others previously issued to Plan Participants for this Plan on the Benefit Plan Date or the amended Benefit Plan Date. This Plan describes Your Benefits, as well as Your rights and responsibilities under the Plan. You are encouraged to read this Benefit Plan carefully.

You should call the Claims Administrator's customer service number on the back of Your ID card if You have questions about Your coverage, or any limits to the coverage available to You. Many of the sections of this Benefit Plan are related to other sections of this Plan. You may not have all of the information You need by reading just one section. Please be aware that Your Physician does not have a copy of Your Benefit Plan, and is not responsible for knowing or communicating Your Benefits to You.

Except for necessary technical terms, common words are used to describe the Benefits provided under this Benefit Plan. "The Claims Administrator," "Us" and "Our" means Blue Cross and Blue Shield of Louisiana. "You," "Your" and "Yourself" means the Plan Participant and/or enrolled Dependent. Capitalized words are defined terms in Article II - "Definitions." A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

FACTS ABOUT THIS HEALTH PLAN

This Plan is a Consumer Driven Health Plan (CDHP). This CDHP coverage may be used in conjunction with a Health Savings Account (HSA), which a Plan Participant sets up through a financial institution. HSAs are portable, tax-advantaged savings accounts that act like a medical IRA. Unused money is rolled over from year to year, grows through interest and investments, and can be used to pay for a wide variety of health and wellness related products and services. The IRS has established eligibility rules for HSAs. Most adults who are covered by a Consumer Driven Health Plan, like this CDHP product, and who have no other first dollar health coverage except for preventive care, may establish an HSA. Plan Participants that choose to take advantage of the Benefits of health savings accounts should learn about the laws affecting HSAs. They may wish to consult a qualified tax or financial advisor to ensure that they are eligible to establish an HSA, that they understand what other types of health coverage they may have without violating the HSA rules, what expenses may be paid from an HSA, and the many tax benefits available to them if they properly comply with all IRS rules on HSA accounts.

This Benefit Plan describes Preferred Provider Organization (PPO) coverage. Plan Participants have an extensive Provider Network available to them – Blue Cross and Blue Shield of Louisiana's PPO Network (hereafter "Network"). Plan Participants can also get care from Providers who are not in this Network, but the Benefit Payment will be paid at a lower percentage.

PLAN PARTICIPANTS WHO GET CARE FROM PROVIDERS IN THEIR NETWORK WILL PAY THE LEAST FOR THEIR CARE AND GET THE MOST VALUE FROM THIS PLAN.

Most Benefits are subject to the Plan Participant's payment of a Deductible as stated in the Schedule of Benefits. After payment of applicable Deductibles, Benefits are subject to two (2) Coinsurance levels (for example: 80/20, 70/30). The Plan Participant's choice of a Provider determines what Coinsurance level applies to the service provided. The Plan will pay the highest Coinsurance level for Medically Necessary services when a Plan Participant obtains care from a Network Provider. The Plan will pay the lower Coinsurance level when a Plan Participant obtains Medically Necessary services from a Non-Network Provider.

Effective January 1, 2016, all Deductibles, Out-of-Pocket Amounts, Coinsurance, Copayments and annual limits (day and dollar) will start over and all Benefits in this Plan will apply on a calendar basis.

CLAIMS ADMINISTRATOR'S PROVIDER NETWORK

Plan Participants choose which Providers will render their care. This choice will determine the amount the Plan pays and the amount the Plan Participant pays for Covered Services. The Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with the Claims Administrator to participate in the Blue Cross and Blue Shield of Louisiana Network and render services to the Plan Participants. These Providers are called "Network Providers." Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's dental network.

To obtain the highest level of Benefit Payment available, the Plan Participant should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Network Provider before the service is rendered. Plan Participants may review a current paper Provider directory or search for a provider outside of the state of Louisiana under National Provider Directory in the Find Care section of **www.bcbsla.com/ogb** or on the free BCBSLA app for your iPhone or Android. Plan Participants may also contact the Plan's customer service department at the number listed on their ID card.

A Provider's status may change from time to time. Plan Participants should always verify the network status of a Provider before obtaining services.

A Provider may be contracted with the Claims Administrator as a Network Provider when providing services at one location, and may be considered Non-Network when rendering services from another location. The Plan Participant should check his Provider directory to verify that the Provider is In-Network at the location where the Plan Participant is seeking care.

Additionally, Providers in Your network may be contracted to perform certain Covered Services, but may not be contracted in Your network to perform other Covered Services. When a Network Provider performs services that the Network Provider is not contracted with the Claims Administrator to perform (such as certain High-Tech Imaging or radiology procedures), claims for those services will be adjudicated at the Non-Network Benefit level. The Plan Participant should make sure to check his Provider directory to verify that the services are In-Network when performed by the Provider or at the Provider's location.

RECEIVING CARE OUTSIDE OF THE NETWORK

The PPO Network is an extensive network. However, Plan Participants choose which Providers will render their care, and Plan Participants may obtain care from Providers who are not in the PPO Network.

The Plan pays a lower level of Benefit Payment when a Plan Participant uses a Provider outside of the Network. Benefit Payment may be based on a lower Allowable Charge, and/or a penalty may apply. Care obtained outside the Claims Administrator's Network means the Plan Participant has a higher Deductible, and/or Coinsurance. In addition, the Plan Participant is responsible for the difference between the Allowable Charge and the billed charge. Therefore, Your Out-of-Pocket costs are greater than if You had stayed In-Network. THESE ADDITIONAL COSTS MAY BE SIGNIFICANT. The amount the Plan Participant is required to pay does not apply to the Out-of-Pocket Amount.

It is recommended that the Plan Participant ask Non-Network Providers to explain their billed charges before care is received outside the Network. Prior to obtaining care outside the Network, You should review the section titled "Sample Illustration of Plan Participant Costs When Using a Non-Network Hospital."

SAMPLE ILLUSTRATION OF PLAN PARTICIPANT COSTS WHEN USING A NON-NETWORK HOSPITAL

NOTE: The following example is for illustration purposes only and may not be a true reflection of the Plan Participant's actual Deductible and Coinsurance amounts. Please refer to the Schedule of Benefits to determine Benefits.

EXAMPLE: A Plan Participant has a PPO Plan with a $500 Deductible Amount. The Plan Participant has 80/20 Coinsurance when he receives Covered Services from Network Hospitals and 70/30 Coinsurance when he receives Covered Services from Non-Network Hospitals. Assume the Plan Participant goes to the Hospital, has previously met his Deductible, and has obtained the necessary Authorizations prior to receiving a non-emergency service. The Provider's billed charge for the Covered Services is $12,000.

The Claims Administrator negotiated an Allowable Charge of $2,500 with its Network Hospitals to render this service. There is no negotiated rate with the Non-Network Hospital**.**

The Plan Participant receives Covered Services from:	**Network Hospital**	**Non- Network Hospital**
Provider's Bill: Allowable Charge:	$12,000 $2,500	$12,000 $2,500
The Plan pays:	$2,000 $2,500 Allowable Charge x 80% Coinsurance = $2,000	$1,750 $2,500 Allowable Charge x 70% Coinsurance = $1,750
Plan Participant pays:	$500 $2,500 Allowable Charge x 20% Coinsurance = $500	$750 $2,500 Allowable Charge x 30% Coinsurance = $1,000
Plan Participant is billed up to the Provider's billed charge	NO	YES
TOTAL PLAN PARTICIPANT PAYS:	$500	$10,250

AUTHORIZATIONS

Some services and supplies require Authorization from the Claims Administrator before services are obtained. Your Schedule of Benefits lists the services, supplies, and Prescription Drugs that require this advance Authorization.

No payment will be made for Organ and Bone Marrow Transplant Benefits or evaluations unless the Claims Administrator Authorizes these services and the services are rendered by a Blue Distinction Center for Transplants for the specific organ or transplant, or a transplant facility in the Blue Cross and Blue Shield of Louisiana PPO Network, unless otherwise approved by the Claims Administrator and the Plan Administrator in writing. Evaluation for Tissue Transplant is not required. To locate an approved transplant facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their ID card.

HOW THE PLAN DETERMINES WHAT IS PAID FOR COVERED SERVICES

When a Plan Participant Uses Network Providers

Network Providers are Providers who have signed contracts with the Claims Administrator or another Blue Cross and Blue Shield Plan to participate in the PPO Network. These Providers have agreed to accept the lesser of billed charges or an amount negotiated as payment in full for Covered Services provided to Plan Participants. This amount is the Network Provider's Allowable Charge. If the Plan Participant uses a Network Provider, this Allowable Charge is used to determine the Plan's payment for the Plan Participant's Medically Necessary Covered Services and the amount that the Plan Participant must pay for his Covered Services.

When a Plan Participant Uses Non-Network Providers

Non-Network Providers are Providers who have not signed a contract with the Claims Administrator or any other Blue Cross and Blue Shield plan to participate in a Blue Cross and Blue Shield PPO Network. These Providers are not in the Claims Administrator's Networks. The Claims Administrator has no fee arrangements with them. The Claims Administrator establishes an Allowable Charge for Covered Services provided by Non-Network Providers. The Allowable Charge will be the lesser of the following:

A. An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;

B. an amount We establish as the Allowable Charge; or

C. the Provider's billed charge. You will receive a lower level of Benefit because You did not go to a Preferred Provider.

The Plan Participant may pay significant costs when he uses a Non-Network Provider. This is because the amount that some Providers charge for a Covered Service may be higher than the established Allowable Charge. Also, Network Providers waive the difference between their actual billed charge and their Allowable Charge, while Non-Network Providers will not.

WHEN A PLAN PARTICIPANT PURCHASES COVERED PRESCRIPTION DRUGS

Some pharmacies have contracted with the Claims Administrator or with its Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base the Plan's payment for a Plan Participant's covered Prescription Drugs and the amount that the Plan Participant must pay for his covered Prescription Drugs.

When a Plan Participant purchases covered Prescription Drugs from a pharmacy that has not contracted with the Claims Administrator or with its Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense, the Allowable Charge is the negotiated amount that most Participating Pharmacies have agreed to accept as payment for drugs dispensed.

To obtain contact information for the contracted specialty pharmacy, the Plan Participant should contact the Claims Administrator or the Claims Administrator's Pharmacy Benefit Manager at the telephone number indicated on His ID card.

ASSIGNMENT OR ATTEMPTED ASSIGNMENT

A Plan Participant's rights and Benefits under this Plan are personal to him and may not be assigned in whole or in part by the Plan Participant. The Claims Administrator will recognize assignments of Benefit Payments to Hospitals if both this Plan and the Provider are subject to La. R.S. 40:2010. If both this Plan and the Provider are not subject to La. R.S. 40:2010, the Claims Administrator will not recognize assignments or attempted assignments of Benefit Payment.

Nothing contained in the written description of health coverage shall be construed to make the Plan or the Claims Administrator liable to any third party to whom a Plan Participant may be liable to for the cost of medical care, treatment, or services.

The Plan reserves the right to pay Network and Non-Network Providers directly instead of paying the Plan Participant.

PLAN PARTICIPANT INCENTIVES AND VALUE-ADDED SERVICES

Sometimes the Claims Administrator offers Plan Participants coupons, discounts, and incentives to enroll in programs, such as pharmacy programs, disease management programs, and wellness programs and activities. The Claims Administrator may offer Plan Participants discounts or financial incentives to use certain Providers for selected Covered Services. We may also offer Plan Participants the opportunity to enroll in health and non-health related programs, as value-added services, to enhance the Plan Participant's experience with Us or his Providers. These incentives and value-added services are not Benefits and do not alter or affect Plan Participant Benefits. They may be offered by the Claims Administrator, affiliated companies, and selected vendors. Plan Participants are always free to reject the opportunities for incentives and value-added services. The Claims Administrator reserves the right to add or remove any and all coupons discounts, incentives, programs, and value-added services at any time without notice to Plan Participants.

HEALTH MANAGEMENT AND WELLNESS TOOLS AND RESOURCES

The Claims Administrator offers Plan Participants a wide range of health management and wellness tools and resources. Plan Participants can use these tools to manage their personal accounts, see claims history, create health records and access a host of online wellness interactive tools. Plan Participants also have access to a comprehensive wellness program that includes a personal health assessment and customized health report to assess health risks based on his history and habits. Exclusive discounts are also available to Plan Participants on some health services such as fitness club memberships, diet and weight control programs, vision and hearing care and more.

CUSTOMER SERVICE

Plan Participants who need to contact the Claims Administrator may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit **www.bcbsla.com/ogb** and go to the box titled Contact Us. Click on Regional Office to find a regional office near you, or click on Contact Information for Our customer service phone and fax numbers, and e-mail and postal addresses.

HOW TO OBTAIN CARE USING BLUECARD® WHILE TRAVELING

THE PLAN PARTICIPANT'S ID CARD OFFERS CONVENIENT ACCESS TO PPO HEALTHCARE OUTSIDE OF LOUISIANA. IF THE PLAN PARTICIPANT IS TRAVELING OR RESIDING OUTSIDE OF LOUISIANA AND NEEDS MEDICAL ATTENTION, PLEASE FOLLOW THESE STEPS:

a. In an Emergency, go directly to the nearest Hospital.

b. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest PPO Network Providers.

c. Use a designated PPO Provider to receive Network Benefits.

d. Present the Plan Participant's ID card to the Provider, who will verify coverage and file Claims for the Plan Participant. (Plan Participants may be required to pay Providers and seek reimbursement).

e. The Plan Participant must obtain any required Authorizations from the Claims Administrator.

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands with a Blue Cross Blue Shield Global® Core provider are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands from a non-Blue Cross Blue Shield Global® Core Provider ARE COVERED AT THE NON-NETWORK BENEFIT LEVEL.

ARTICLE II. DEFINITIONS

Accidental Injury – A condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, injuries caused by the act of chewing do not constitute an injury caused by external force. If Benefits are available for the treatment of a particular injury, Benefits will be provided for an injury that results from an act of domestic violence or a medical condition.

Admission – The period from entry (Admission) into a Hospital or Skilled Nursing Facility or Unit for Inpatient care, until discharge. In counting days of care, the date of entry and the date of discharge are counted as one (1) day.

Adverse Benefit Determination – Means denial or partial denial of a Benefit, in whole or in part, based on:

A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment determined to be experimental or Investigational;

B. the Plan Participant's eligibility to participate in the Benefit Plan;

C. any prospective or retrospective review determination; or

D. a Rescission of Coverage.

Affordable Care Act (ACA and/or PPACA) – The Patient Protection and Affordable Care Act, a United States federal statute signed into law on March 23, 2010, together with the Health Care and Education Reconciliation Act of 2010, and other amending laws, as well as regulations validly promulgated pursuant thereto.

Allied Health Facility – An institution, other than a Hospital, licensed by the appropriate state agency where required, and/or approved by Us to render Covered Services.

Allied Health Professional – A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, and/or approved by Us to render Covered Services. For coverage purposes under this Benefit Plan, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, Physician assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by Us to render Covered Services.

Allied Provider – Any Allied Health Facility or Allied Health Professional.

Allowable Charge –

A. For Preferred Providers and Participating Providers - The lesser of the billed charge or the amount established by the Claims Administrator or negotiated as the maximum amount allowed for services from these Providers covered under the terms of this Benefit Plan.

B. For Non-Participating Providers – The lesser of:

    1. An amount We establish based on Our choice of Medicare’s published fee schedule, what Medicare pays, or what Medicare allows for the service;

    2. an amount We establish as the Allowable Charge;

    3. or the Provider’s billed charge.

Alternate Facility – a healthcare facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Alternative Benefits – Benefits for services not routinely covered under this Benefit Plan but which the Plan may agree to provide when it is beneficial both to the Plan Participant and to the Group.

Ambulance Service – Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

Ambulatory Surgical Center – An Allied Health Facility Provider that is established with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight, and which offers the following services whenever a patient is in the center: (1) anesthesia services as needed for medical operations and procedures performed; (2) provisions for physical and emotional well-being of patients; (3) provision for emergency services; (4) organized administrative structure; and (5) administrative, statistical and medical records.

Amendment – Any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the Claims Administrator or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Enrollment – A period of time, designated by the Group, during which an Employee/Retiree may enroll for Benefits under this Benefit Plan or any other Group Plan.

Appeal – A written request from a Plan Participant or authorized representative to change an Adverse Benefit Determination made by the Claims Administrator.

Applied Behavior Analysis (ABA) – The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Providers of ABA shall be licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state.

Authorization (Authorized) – A determination by the Claims Administrator regarding an Admission, continued Hospital stay, or other healthcare service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the healthcare setting, or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Plan Participant's choice of Provider. If a required authorization is not obtained prior to services being rendered by a Network Provider, services are not covered and the Provider cannot bill the Plan Participant for those services that require a prior authorizations. If a service is being rendered by a Non-network Provider and any required authorization has not been obtained prior to services being rendered, benefits otherwise payable will be reduced to fifty percent (50%).

Authorized Representative – A person, including the Participant’s treating Provider, to whom the Plan Participant has given written consent to represent the Plan Participant in a review of an Adverse Benefit determination.

Autism Spectrum Disorders (ASD) – Any of the pervasive neurobiological development disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM). These disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. ASD includes conditions such as Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified.

Bed, Board and General Nursing Service – Room accommodations, meals and all general services and activities provided by a Hospital Employee for the care of a patient. This includes all nursing care and nursing instructional services provided as a part of the Hospital's bed and board charge.

Benefits – Coverage for healthcare services, treatments, procedures, equipment, drugs, devices, items or supplies covered under this Plan. Benefits covered by the Plan are based on the Allowable Charge for Covered Services.

Benefit Payment – Payment of Eligible Expenses based on the Allowable Charge, at the percentage shown in the Schedule of Benefits after applicable Deductibles, Copayments, and Coinsurance.

Benefit Period – A calendar year, January 1 through December 31. For new Plan Participants, the Benefit Period begins on the Effective Date and ends on December 31 of the same year.

Benefit Plan – The health benefit program and any prescription drug or pharmacy benefits program or Formulary (to the extent any pharmacy or prescription drug benefit is provided under this Plan) established by the Group for Plan Participants.

Bone Mass Measurement – A radiologic or radioisotopic procedure or other scientifically proven technologies performed on an individual for the purpose of identifying bone mass or detecting bone loss.

Brand-Name Drug – A Prescription Drug that is a patented drug marketed by the original drug manufacturer following its Food and Drug Administration ("FDA") approval, or that the Claims Administrator identifies as a Brand-Name product. The Claims Administrator classifies a Prescription Drug as a Brand-Name Drug based on a nationally recognized pricing source, therefore all products identified as a "Brand Name" by the manufacturer or pharmacy may not be classified as a Brand-Name Drug by the Claims Administrator.

Cardiac Rehabilitation – A structured program that provides coordinated, multi-faceted interventions including supervised exercise training, education, counseling and other secondary prevention interventions. It is designed to speed recovery from acute cardiovascular events such as myocardial infarction, myocardial revascularization, or hospitalization for heart failure and to improve functional and psychosocial capabilities.

Care Coordination – Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Plan Participant's healthcare needs across the continuum of care.

Care Coordinator Fee – A fixed amount paid by Blue Cross and Blue Shield of Louisiana to Providers periodically for Care Coordination under a Value-Based Program.

Case Management – A method of delivering patient care that emphasizes quality patient outcomes with efficient and cost-effective care. The process of Case Management systematically identifies high-risk patients and assesses opportunities to coordinate and manage patients' total care to ensure the optimal health outcomes. Case Management is a service offered at the Plan's option administered by medical professionals, which focuses on unusually complex, difficult or catastrophic illnesses. Working with the Plan Participant's Physician(s) and subject to consent by the Plan Participant and/or the Plan Participant's family/caregiver, the Case Management staff will manage care to achieve the most efficient and effective use of resources.

Cellular Immunotherapy – A treatment involving the administration of a patient's own (autologous) or donor (allogeneic) anti-tumor lymphocytes following a lymphodepleting preparative regimen.

Child or Children includes:

A. The issue of a marriage of the Employee/Retiree;

B. A natural Child of the Employee/Retiree;

C. A legally adopted Child of the Employee/Retiree or a Child placed for adoption with the Employee/Retiree;

D. The Child of a male Employee/Retiree, if a court of competent jurisdiction has issued an order of filiation declaring the paternity of the Employee/Retiree for the Child or the Employee/Retiree has formally acknowledged the Child;

E. The issue of a previous marriage or a natural or legally adopted Child of the Employee's/Retiree's legal Spouse, hereinafter "stepchild", which stepchild has not been adopted by the Employee/Retiree and for whom the Employee/Retiree does not have court-ordered legal custody;

F. A grandchild in the court-ordered legal custody of and residing with the grandparent Employee/Retiree, until the end of the month the grandchild attains the age of twenty-six (26);

G. A dependent for whom the Employee/Retiree has court-ordered legal custody or court-ordered legal guardianship but who is not a Child or grandchild of the Employee/Retiree, until the end of the month the custody or guardianship order expires or the end of the month the dependent attains the age of eighteen (18), whichever is earlier; or

H. A grandchild or dependent of a dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent, or a child for whom the Employee/Retiree has current provisional custody, which grandchild/child has not been adopted by the Employee/Retiree and for whom the Employee/Retiree has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a "Child" as of December 31, 2015.

Chiropractic Services – The diagnosing of conditions associated with the functional integrity of the spine and the treatment of such conditions by adjustment, manipulation, and the use of physical and other properties of heat, light, water, electricity, sound, massage, therapeutic exercise, mobilization, mechanical devices such as mechanical traction and mechanical massage, and other rehabilitative measures for the purpose of correcting interference with normal nerve transmission and expression.

Claim – A written or electronic proof, in a form acceptable to the Claims Administrator, of charges for Covered Services that have been incurred by a Plan Participant during the time period the Plan Participant was insured under this Benefit Plan. The provisions in effect at the time the service or treatment is received shall govern the processing of any Claim expense actually covered as a result of the service or treatment rendered.

Claims Administrator – The entity with whom the Group (Plan Administrator) has contracted to handle the claims payment functions of its Plan. For purposes of this Plan, the Claims Administrator is Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service and Indemnity Company).

Cleft Lip and Cleft Palate Services – Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

COBRA – The federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 with amendments.

Code – The Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.

Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a pair of percentages, a percentage that the Plan pays and a percentage that the Plan Participant pays. Once the Plan Participant has met any applicable Deductible Amount, the Plan Participant's percentage will be applied to the Allowable Charges for Covered Services to determine the Plan Participant's financial responsibility. The Plan's percentage will be applied to the Allowable Charges for Covered Services to determine the Benefit Payment provided.

Company – Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service & Indemnity Company).

Complaint – An oral expression of dissatisfaction with the Claims Administrator or Provider services.

Complication(s) – A medical condition, arising from an adverse event or consequence, which requires services, treatment or therapy and which is determined by BCBSLA, based on substantial medical literature and experience, to be a direct and consequential result of another medical condition, disease, service or treatment. Solely as an example, a pulmonary embolism after Surgery would be a Complication of the Surgery.

Concurrent Care – Hospital Inpatient medical and surgical care by a Physician, other than the attending Physician: (1) for a condition not related to the primary diagnosis or, (2) because the medical complexity of the patient's condition requires additional medical care.

Concurrent Review – A review of Medical Necessity, appropriateness of care, or level of care conducted during a patient's Inpatient facility stay or course of treatment.

Congenital Anomaly – A condition existing at or from birth, which is a deviation from the common form or norm. Only deviations that impact bodily functions are covered. Examples of Congenital Anomalies that do not impact bodily function and are not covered include, but are not limited to: protruding ears, birthmarks, webbed fingers and toes, and asymmetrical breasts. Cleft Lip and Cleft Palate are covered Congenital Anomalies; other conditions relating to teeth or structures supporting the teeth are not covered. We will determine which conditions are covered as Congenital Anomalies.

Consultation – Another Physician's opinion or advice as to the evaluation or treatment of a Plan Participant, which is furnished upon the request of the attending Physician. These services are not intended to include those consultations required by Hospital rules and regulations, anesthesia consultations, routine consultations for clearance for Surgery, or consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge.

Convalescent/Maintenance Care or Rest Cure – Treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by one's self, family, or other caregivers who are not eligible Providers. The services are primarily designed to help the patient with daily living activities, maintain the patient's present physical and mental condition, and/or provide a structured or safe environment.

Cosmetic Surgery – Any operative procedure, treatment, or service, or any portion of an operative procedure, treatment, or service performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form. An operative procedure, treatment, or service is not considered Cosmetic Surgery if it restores bodily function or corrects deformity to restore function of a part of the body that an Accidental Injury, disease, disorder or covered Surgery has altered.

Covered Person – An Active Employee, a Retiree, his eligible Dependent(s), or any other individual eligible for coverage under the Schedule of Eligibility or state or federal law for whom the necessary application forms have been completed, for whom the required contribution has been made, and for whom the Plan Administrator has accepted Eligibility and enrolled into the Plan. The term Covered Person, defined here, is used interchangeably with the term Plan Participant.

Covered Service – A service or supply specified in this Benefit Plan for which Benefits are available when rendered by a Provider.

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to: personal care, feeding, dressing, bathing, homemaking, moving the patient; acting as companion or sitter; supervising medication that can usually be self-administered; treatment or services that any person may be able to perform with minimal instruction; or long-term treatment for a condition in a patient who is not expected to improve or recover during periods when the medical condition of the patient who requires the service is not changing. The Claims Administrator determines which services are Custodial Care.

Date Acquired – The date a Dependent of a covered Employee/Retiree is acquired in the following instance and on the following dates only:

A. Spouse – the date of marriage;

B. Child or Children

   1. Natural Children – the date of birth

   2. Children placed for adoption with the Employee/Retiree:

      Agency adoption – the date the adoption contract was executed between the Employee/Retiree and the adoption agency.

      Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee/Retiree. The Plan Administrator must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first.

   3. Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship – the date of the court order granting legal custody or guardianship

   4. From date of court order of filiation declaring paternity or date of formal acknowledgment of the Child;

   5. Stepchild – the date of the marriage of the Employee/Retiree to his/her Spouse.

Day Rehabilitation Program – A program that provides greater than one (1) hour of Rehabilitative Care, upon discharge from an Inpatient Admission.

Deductible Amount –

A. Individual Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of Allowable Charges for Covered Services, which a Plan Participant with Employee Only coverage must pay within a Benefit Period before the Plan starts paying benefits.

   Network and Non-Network Benefit categories may each carry a separate Individual Deductible Amount as shown in the Schedule of Benefits.

   The Deductible does not apply to Preventive and Wellness Care.

B. Family Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of Allowable Charges for Covered Services, which may be paid by a family within a Benefit Period before the Plan starts paying Benefits. If the Benefit Plan includes more than one (1) Plan Participant, the Individual Deductible Amount is not applicable. The Family Deductible Amount applies. After the Family Deductible Amount is met, this Plan starts paying Benefits for all covered members of the family, for the remainder of the Benefit Period.

Network and Non-Network Benefit categories may each carry a separate Family Deductible Amount as shown in the Schedule of Benefits.

Dental Care and Treatment – All procedures, treatment, and Surgery considered to be within the scope of the practice of dentistry, which is defined as that practice in which a person:

A. represents himself/herself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;

B. takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or

C. furnishes, supplies, constructs, reproduces, repairs or offers to furnish, supply, construct, reproduce, or repair prosthetic dentures, bridges, or other substitute for natural teeth to the user or prospective user.

Dependent – Any of the following persons who (a) are enrolled for coverage as Dependents by completing appropriate enrollment documents, if they are not also covered as an Employee/Retiree, and (b) whose relationship to the Employee/Retiree has been Documented, as defined herein:

A. The covered Employee's/Retiree's Spouse;

B. A Child from Date Acquired until end of month of attainment of age twenty-six (26), except for the following:

    1. A grandchild or dependent of a dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which grandchild or dependent of a dependent was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until end of month the parent Dependent Child is no longer enrolled on or eligible to participate in the Plan, the end of the month the grandchild or dependent of a dependent turns twenty-six (26), or the grandchild or dependent of a dependent no longer meets the eligibility requirements under this Plan, whichever is earlier;;

    2. A child for whom the Employee/Retiree has current provisional custody and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which child was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until the end of the month of the 2016 anniversary date of the existing provisional custody document, the end of the month the child reaches the age of eighteen (18), or December 31, 2016, whichever is earlier;

    3. A Child, who is not the Child or grandchild or the Employee/Retiree, for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship but who has not been adopted by the Employee/Retiree, from Date Acquired until the end of the month the custody/guardianship order expires or the end of the month the Child reaches the age of eighteen (18), whichever is earlier;

    4. A stepchild of the Employee/Retiree, which stepchild has not been adopted by the Employee/Retiree and for whom the Employee/Retiree does not have court-ordered legal custody, until the earliest of:

        a. The end of the month the Employee/Retiree is no longer married to the stepchild's parent;

        b. The end of the month of the death of the Employee's/Retiree's Spouse who is the stepchild's parent; or

        c. The end of the month the stepchild attains the age of twenty-six (26).

C. A Child of any age who meets the criteria set forth in the Eligibility Article of this Benefit Plan.

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures recognized by the Plan as accepted medical practice, rendered because of specific symptoms, and which are directed toward detection or monitoring of a definite condition, illness or injury. A Diagnostic Service must be ordered by a Provider prior to delivery of the service.

Disability – The Plan Participant, who is an Employee and is prevented, solely because of a disease, illness, accident, or injury, from engaging in his or her regular or customary occupation and is performing no work of any kind for compensation or profit; or, a Dependent who is prevented from substantially engaging in all the normal activities of a person of like age in good health solely because of a disease, illness, accident, or injury.

Documented (with respect to a Dependent of an Employee/Retiree) – The following written proof of relationship to the Employee/Retiree has been presented for inspection and copying to the Group, or to a representative of the Employee's/Retiree's Participant Employer designated by OGB:

A. The covered Employee's/Retiree's Spouse - Certified copy of certificate of marriage indicating date and place of marriage.

B. Child:

1. Natural or legally adopted Child of Employee/Retiree - Certified copy of birth certificate listing Employee/Retiree as parent or certified copy of legal acknowledgment of paternity signed by the Employee/Retiree, certified copy of court order of filiation declaring paternity of the Employee/Retiree or certified copy of adoption decree naming Employee/Retiree as adoptive parent.

2. Stepchild - Certified copy of certificate of marriage to Spouse and birth certificate or adoption decree listing Spouse as natural or adoptive parent.

3. Child placed with Your family for adoption by agency adoption or irrevocable Act of Voluntary Surrender for private adoption. Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable Act of Voluntary Surrender.

4. Child for whom You have been granted court-ordered legal guardianship or court-ordered custody - Certified copy of the signed court order granting legal guardianship or custody.

C. Child age twenty-six (26) or older who is incapable of self-sustaining employment by reason of physical or mental disability who was covered prior to age twenty-six (26). No earlier than six (6) months prior to attaining age twenty-six (26) documentation as described in B.1. through B.4. above, together with an application for continued coverage must be filed with the Plan Administrator on a form designated by the Plan Administrator.

1. This application must be accompanied by an attestation from the Dependent Child's attending Physician setting forth the specific physical or mental disability and certifying that the Child is incapable of self-sustaining employment by reason of that disability. The Plan Administrator may require additional medical or other supporting documentation regarding the disability to process the application.

2. After the initial approval, the Plan Administrator may require the submission of additional medical or other supporting documentation substantiating the continuance of the disability, but not more frequently than annually, as a precondition to continued coverage.

D. Such other written proof of relationship to the Employee/Retiree deemed sufficient by the Group.

Durable Medical Equipment – Items and supplies which are used to serve a specific therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are not disposable, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home.

Effective Date – The date when the Plan Participant's coverage begins under this Benefit Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 AM on this date.

Elective Admission – Any Inpatient Hospital Admission, whether it be for surgical or medical care, for which a reasonable delay will not unfavorably affect the outcome of the treatment.

Eligible Expenses – the charges incurred for Covered Services.

Eligible Person – A person entitled to apply to be a Plan Participant or a Dependent as specified in the Schedule of Eligibility.

Emergency – See "Emergency Medical Condition"

Emergency Admission – An Inpatient Admission to a Hospital resulting from an Emergency Medical Condition.

Emergency Medical Condition (or "Emergency") – A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the health of the person , or with respect to a pregnant woman the health of the woman or her unborn Child, in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

Emergency Medical Services – Those medical services necessary to screen, evaluate and stabilize an Emergency Medical Condition.

Employee – A full-time Employee as defined by the respective Participant Employer in accordance with state law, and any Full-Time Equivalent.

Enrollment Date – The first date of coverage under this Benefit Plan.

Erectile Dysfunction – A condition in which the Plan Participant is unable to get or keep an erection firm enough to achieve penetration during sexual intercourse. Erectile Dysfunction can be a short-term or long-term condition.

Expedited Appeal – A request for immediate internal review of an Adverse Benefit Determination, which involves any of the following situations:

A. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function.

B. In the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

C. Decision not to Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

Expedited External Appeal – A request for immediate review, by an Independent Review Organization (IRO), of an initial Adverse Benefit Determination, which involves any of the following:

A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function, or a decision not to Authorize continued services for Plan Participants currently in the emergency room, under observation, or receiving Inpatient care.

B. A denial of coverage based on a determination the recommended or requested healthcare service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Plan Participant's health, including severe pain, potential loss of life, limb or major bodily function.

External Appeal – A request for review by an Independent Review Organization (IRO), to change an initial Adverse Benefit Determination made by the Company or to change a final Adverse Benefit Determination rendered on Appeal. External Appeal is available upon request by the Plan Participant or authorized representative for Adverse Benefit Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission of Coverage.

Formulary – The list of prescription drugs that are covered by the pharmacy benefits program established by the Office of Group Benefits and as amended from time to time. The Formulary may contain preferred and non-preferred tiers and may or may not be administered by the Claims Administrator.

Full Time Equivalent (FTE) – A full-time equivalent Employee who is employed on average 30 or more hours per week, as defined under Code Section 4980H and determined pursuant to the regulations issued thereunder.

Gene Therapy – A treatment involving the administration of genetic material to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use.

Generic Drug – A Prescription Drug that is equivalent to a Brand-Name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use; or that the Claims Administrator identifies as a Generic Drug. Classification of a Prescription Drug as a Generic Drug is determined by the Claims Administrator and not by the manufacturer or pharmacy. The Claims Administrator classifies a Prescription Drug as a Generic Drug based on a nationally recognized pricing source; therefore, all products identified as a "Generic" by the manufacturer or a pharmacy may not be classified as a Generic by the Claims Administrator.

Gestational Carrier – A woman who agrees to engage in a process by which she attempts to carry and give birth to a child born as the result of an in utero transfer of a human embryo to which she makes no genetic contribution.

Grievance – A written expression of dissatisfaction with the quality of care or services received from the Claims Administrator or a Network Provider.

Group – State of Louisiana Office of Group Benefits who is the Plan Administrator.

High-Tech Imaging – Imaging services, including, but not limited to MRIs, MRAs, CT scans, PET scans and nuclear cardiology.

HIPAA – The Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and Federal Regulations promulgated pursuant thereto.

HIPAA Special Enrollment Event – An event as specified by federal law that entitles an Employee and the Employee's Dependents an opportunity to enroll in, and change, if desired, healthcare coverage offered by OGB outside of Annual Enrollment.

Home Health Care – Health services rendered in the individual's place of residence by an organization licensed as a Home Health Care agency by the appropriate state agency and approved by the Claims Administrator. These organizations are primarily engaged in providing to individuals, at the written direction

of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse (RN) licensed to practice in the state.

Hospice Care – Provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Plan Participants and their families during the final stages of terminal illness. Hospice Care is centrally coordinated through an interdisciplinary team directed by a Physician and provided by or through a Hospice Care agency approved by the Plan.

Hospital – An institution that is licensed by the appropriate state agency as a general medical surgical Hospital. The term Hospital may also include an institution that primarily provides health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians. Nursing services are provider twenty-four (24) hours per day. A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Implantable Medical Devices – A medical device that is surgically implanted in the body, is not reusable, and can be removed.

Independent Review Organization (IRO) – An Independent Review Organization, not affiliated with Us, which conducts external reviews of final Adverse Benefit Determinations. The decision of the IRO is binding on both the insured and the Company.

Infertility – The inability of a couple to conceive after one (1) year of unprotected intercourse.

Informal Reconsideration – A telephone request by the Plan Participant's Provider to the Claims Administrator's Medical Director, or to a peer reviewer for additional review of an adverse Utilization Management determination. An Informal Reconsideration is available only if requested within ten (10) calendar days of the date of the initial denial or adverse Concurrent Review determination.

Injury – Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient – A Plan Participant who is a registered bed patient for whom a Bed, Board and General Nursing Service charge is made. An Inpatient's medical symptoms or condition must require continuous twenty-four (24) hour a day Physician and nursing intervention.

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Intensive Outpatient Programs – Intensive outpatient programs are defined as having the capacity for planned, structured, service provision of at least two (2) hours per day and three (3) days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatment." (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge).

Intermediate Care – Mental Health or Substance Use Disorder treatment that encompasses one the following:

- Care at a Residential Treatment Facility.

- Care at a Partial Hospitalization/Day Treatment Program.

- Care through an Intensive Outpatient Treatment Program.

Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination the Claims Administrator makes that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, according to the consensus of opinion among experts as shown by reliable evidence, including:

    1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);

    2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or

    3. reference to federal regulations; or

C. whether the medical treatment, procedure, drug, device, or biological product demonstrates improved health outcomes according to the consensus of opinion among experts as shown by reliable evidence, including:

    1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);

    2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or

    3. reference to federal regulations.

Life-Threatening Illness – A severe, serious, or acute condition for which death is probable.

Low-Tech Imaging – Imaging services which include, but are not limited to x-rays, machine tests, diagnostic imaging and radiation therapy. If an image is defined as a High-Tech Image, then it is not a Low-Tech Image.

Medically Necessary (or Medical Necessity) – A service, treatment, procedure, equipment, drug, device, item, or supply, which, in the judgment of the Claims Administrator:

A. Is appropriate and consistent with a Covered Person's diagnosis and treatment as well as with nationally accepted medical standards; and

B. Is not primarily for personal comfort or convenience, Custodial Care, or Convalescent/Maintenance Care or Rest Cure.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychoses, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by La. R.S. 22:1043 (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis not otherwise specified when diagnosed in a Child under seventeen (17) years of age; Rett's Disorder; and Tourette's Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic mental disorders, to be determined by the Plan. The definition of Mental Disorder (Mental Health) shall be the basis for determining benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Multi-Source Brand Drug – A Brand-Name Drug for which a Generic Drug equivalent is available.

Negotiated Arrangement ("Negotiated National Account Arrangement") – An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard® Program.

Network – A Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator.

Network Benefits – Benefits for Covered Health Services received from a Network Physician, Network facility, or other Network provider.

Network Provider – A Provider that has signed an agreement with the Claims Administrator or another Blue Cross and Blue Shield plan to participate as a member of the PPO Network or another Blue Plan's PPO Network. This Provider may also be referred to as an In-Network Provider.

Non-Network Benefits – Benefits for Covered Health Services received from a Non-Network Physician, Non-Network facility, or other Non-Network provider.

Non-Network Provider – A Provider who is not a member of the Claims Administrator's PPO Network or another Blue Cross and Blue Shield plan PPO Network. This Provider may also be referred to as an Out-of-Network Provider.

Occupational Therapy (OT) – The evaluation and treatment of physical injury or disease, cognitive impairments, congenital or developmental disabilities, or the aging process by the use of specific goal directed activities, therapeutic exercises and/or other interventions that alleviate impairment and/or improve functional performance. These can include the design, fabrication or application of orthotic devices; training in the use of orthotic and prosthetic devices; design, development, adaptation or training in the use of assistive devices; and the adaptation of environments to enhance functional performance.

Office of Group Benefits (OGB) – The entity created and empowered to administer the programs of benefits authorized or provided for under the provisions of Chapter 12 of Title 42 of the Louisiana Revised Statutes.

Orthotic Device – A rigid or semi-rigid supportive device, which restricts or eliminates motion of a weak or diseased body part.

Out-of-Pocket Amount –

A. Individual Out-of-Pocket Amount – The maximum amount, as shown in the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amounts and Coinsurance), which may be paid by a Plan Participant with Employee Only coverage, within a Benefit Period. After the Individual Out-of-Pocket is met, the Plan will pay one hundred percent (100%) of the Allowable Charge for Covered Services.

   Network and Non-Network Benefit categories may each carry a separate Individual Out-of-Pocket

Amount as shown in the Schedule of Benefits.

B. Family Out-of-Pocket Amount – The maximum amount, as shown in the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amounts and Coinsurance), which may be paid by a family within a Benefit Period. If the Benefit Plan covers more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable Charge for Covered Services, for all covered members of the family, for the remainder of the Benefit Period, whether each member has met the Per Member within a Family Out-of-Pocket Amount.

   Network and Non-Network Benefit categories may each carry a separate Family Out-of-Pocket Amount as shown in the Schedule of Benefits.

C. Per Member within a Family Out-of-Pocket Amount – The maximum dollar amount, as shown in the Schedule of Benefits, of non-reimbursable expenses for Network Covered Services, which may be paid by one (1) family member within a Benefit Period. After the Per Member within a Family Out-of-Pocket Amount is met, the plan will pay one hundred percent (100%) of the Allowable Charge for Network Covered Services, for that family member, for the remainder of the Benefit Period. No family member may contribute more than the Per Member within a Family Out-of-Pocket Amount towards satisfaction of the Family Out-of-Pocket Amount.

Outpatient – A Plan Participant who receives services or supplies while not an Inpatient.

Outpatient Surgical Facility – An Ambulatory Surgical Center licensed by the state in which services are rendered.

Over-Age Dependent – A Dependent Child (or Grandchild) who is age 26 or older, reliant on Employee for support, and is incapable of sustaining employment because of an mental or physical disability that began prior to age 26. Coverage of the Over-Age Dependent may continue after age 26 for the duration of incapacity if, prior to the Dependent Child reaching age 26, an application for continued coverage with current medical information from the Dependent Child's attending Physician is submitted to the Plan. The Plan may require additional or periodic medical documentation regarding the Dependent Child's mental or physical disability as often as it deems necessary, but not more frequently than once a year after the two year period following the child's 26th birthday. The Plan may terminate coverage of the Over-Age Dependent if the Plan determines the Dependent Child is no longer reliant on Employee for support or is no longer mentally or physically disabled to the extent he is incapable of sustaining employment.

Partial Hospitalization Programs – Structured and medically supervised day, evening and/or night treatment programs. Program services are provided to patients at least four (4) hours per day and are available at least three (3) days per week, although some patients may need to attend less often. The services are of essentially the same nature and intensity (including medical and nursing) as would be provided in a Hospital except that the patient is in the Hospital less than twenty-four (24) hours per day. The patient is not considered a resident at the Hospital. The range of services offered is designed to address a Mental Health and/or Substance Use Disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

Participant Employer – A state entity, school board, or a state political subdivision authorized by law to participate in this Benefit Plan.

Pharmacy Benefit Manager (PBM) – A third party administrator of Prescription Drug programs.

Physical Therapy – The treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Physician – A Doctor of Medicine or a Doctor of Osteopathy, legally qualified and licensed to practice medicine and practicing within the scope of his license at the time and place service is rendered.

Plan – The health benefit program and any prescription drug or pharmacy benefits program or Formulary (to the extent any prescription drug or pharmacy benefit is provided under this Plan) established by the Group for Plan Participants.

Plan Administrator – Office of Group Benefits, who administers these Benefits on behalf of State of Louisiana, for eligible Employees/Retirees and Dependents for Participant Employers.

Plan Participant – An Active Employee/Retiree, his eligible Dependent(s), or any other individual eligible for coverage under the Schedule of Eligibility or state or federal law for whom the necessary application forms have been completed, for whom the required contribution has been made, and for whom the Plan Administrator has accepted Eligibility and enrolled into the Plan. The term Plan Participant, defined here, is used interchangeably with the term Covered Person.

Plan Year – The period from January 1, or the date the Plan Participant first becomes covered under the Plan, through December 31.

Pregnancy Care – Treatment or services related to all care prior to delivery, delivery, post-delivery, and any Complications arising from pregnancy.

Prescription Drugs – Medications, which includes Specialty Drugs, the sale or dispensing of which legally requires the order of a Physician or other healthcare professional and that carry the federally required product legend stipulating that such drugs may not be dispensed without a prescription, and which are currently approved by the FDA for safety and effectiveness, subject to the Limitations and Exclusions Article.

Prescription Drug Copayment – The amount a Plan Participant must pay for each prescription at a participating pharmacy at the time a prescription is filled. A different Copayment may be required for the different drug tiers purchased at a retail pharmacy or through the mail.

Preventive Services or Recommended Preventive Services – Healthcare services designed for promotion or maintenance of health and prevention of disease. Preventive Services include, but are not limited to, screening to identify people at risk of developing specific problems, counseling, health education, immunization programs and other necessary intervention to avert a health problem. This Plan provides Preventive Services Benefits in accordance with the following guidelines:

A. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. Recommendations of the United Sates Preventive Services Task Force are not required to be covered immediately after the release of the recommendation or guideline. Timing rules apply by law.

B. Immunizations for routine use in Children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

C. With respect to infants, Children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

D. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Private Duty Nursing Services – Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN), to provide continuous skilled nursing care, one-on-one for an individual patient.

Prosthetic Appliance or Device – Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part. When referring to limb prostheses, it is an artificial limb designed to maximize function, stability, and safety of the patient, that is not surgically implanted and that is used to replace a missing limb. Limb Prosthetics do not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Prosthetic Services – The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. Also includes medically necessary clinical care.

Provider – A Hospital, Allied Health Facility, Physician, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by the Claims Administrator. If a Provider is not subject to state or federal licensure, the Claims Administrator has the right to define all criteria under which a Provider's services may be offered to Plan Participants in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

A. Preferred Provider (Preferred Care Provider) – A Provider who has entered into a contract with the Claims Administrator to participate in its Preferred Care PPO Network, as shown in the Schedule of Benefits. This Provider is also referred to as a Network Provider.

B. Participating Provider – A Provider that does not have a signed contract with the Claims Administrator, but has a signed contract with Our parent company, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan to participate in its Provider networks.

C. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.

D. Quality Blue Primary Care (QBPC) Provider – A Provider who is a family practitioner, general practitioner, internist, geriatrician, nurse practitioner or physician assistant, and who has signed an agreement to participate in the Quality Blue Primary Care program.

Provider Incentive – An additional amount of compensation paid to a healthcare Provider by a payer, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group or population of covered persons.

Recovery – With respect to Subrogation and Reimbursement, Recovery means any and all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for losses allegedly caused by injury or sickness, whether or not the losses reflect medical or dental charges covered by the Plan.

Pulmonary Rehabilitation – A comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors.

Rehabilitative Care – Healthcare services and devices that help a person keep, resume or improve skills and functioning for daily living that have been lost or impaired because a patient was sick, hurt or disabled. These services may include Physical Therapy, Occupational Therapy, Speech-Language Pathology, Cardiac Rehabilitation, Pulmonary Rehabilitation and psychiatric rehabilitation services in a variety of inpatient and/or Outpatient settings.

Repatriation – The act of returning to the country of birth, citizenship or origin.

Rescission of Coverage – Cancellation or discontinuance of coverage that has retroactive effect. This includes a cancellation that treats a Plan Participant's coverage as void from the time of enrollment or a cancellation that voids Benefits paid up to one year before the cancellation.

Residential Treatment Center – A twenty-four (24) hour, non-acute care treatment setting for the active treatment of specific impairments of Mental Health or Substance Use Disorder.

Retail Health Clinic – A non-emergency medical health clinic providing limited primary care services and operating generally in retail stores and outlets.

Retiree – An individual, who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

A. Immediately received a retirement plan distribution from an approved state or governmental agency defined benefit plan;

B. Was not eligible for participation in such plan or legally opted not to participate in such plan; and either:

    1. Began employment prior to September 15, 1979, has ten years of continuous state service, and reached the age of sixty five (65); or

    2. Began employment after September 16, 1979, has ten years of continuous state service, and has reached the age of seventy (70); or

    3. Began employment after July 8, 1992, has ten years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or

    4. Maintained continuous coverage with the Plan as an eligible Dependent until he became eligible to receive a retirement benefit from an approved state governmental agency defined Benefit Plan as a former State Employee.

C. Immediately received a retirement plan distribution from a state-approved or state governmental agency approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.

D. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items A, B, or C above.

Skilled Nursing Facility or Unit – A facility licensed by the state in which it operates and is other than a nursing home, or a unit within a Hospital (unless skilled nursing in the nursing home or unit within a Hospital was specifically approved by the Claims Administrator), that provides:

A. Inpatient medical care, treatment and skilled nursing care as defined by Medicare and which meets the Medicare requirements for this type of facility;

B. Full-time supervision by at least one Physician or Registered Nurse;

C. Twenty-four (24) hour nursing service by Registered Nurses or Licensed Practical Nurses; and

D. Utilization review plans for all patients.

Special Care Unit – A designated Hospital unit which is approved by the Claims Administrator and which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, such as an intermediate care neonatal unit, telemetry unit for heart patients, or an isolation unit.

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Plan) within thirty (30) days of experiencing a HIPAA Special Enrollment Event, including but not limited to, losing other comparable health coverage under certain circumstances enumerated by Law (unless a longer period is required by applicable Law) or acquiring a new Dependent as a result of marriage, birth, adoption, or placement for adoption.

Specialty Drugs – Specialty Drugs are typically high in cost and have one or more of the following characteristics:

A. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.

B. Coordination of care is required prior to drug therapy initiation and/or during therapy.

C. Unique patient compliance and safety monitoring requirements.

D. Unique requirements for handling, shipping and storage.

E. Restricted access or limited distribution.

Specialty drugs also include biosimilars. Biosimilars are drugs that are similar to currently marketed Brand Name drugs, but do not have the exact same active ingredient. Biosimilars are not considered Generic Drugs.

Speech/Language Pathology Therapy – The treatment used to manage speech/language, cognitive-communication and swallowing disorders, with the goals directed towards improving or restoring function.

Spouse – The Employee's/Retiree's Spouse pursuant to a marriage recognized under state law where the marriage was entered.

Subrogation and Reimbursement – The Plan's right to recover issued Benefit Payments for treatment of a Plan Participant's accident-related injuries.

Substance Use Disorder – A pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more criteria occurring within a 12-month period, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM). The definition of Substance Use Disorder shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Surgery –

A. the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic exams, incisional and excisional biopsies and other invasive procedures;

B. the correction of fractures and dislocations;

C. Pregnancy Care to include vaginal deliveries and caesarean sections;

D. usual and related pre-operative and post-operative care; or

E. other procedures as defined and approved by the Plan.

Telehealth Services – A mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, self-management of patients, and caregiver support at a distance from healthcare Providers approved by Claims Administrator to render Telehealth Services. Telehealth Services give Providers the ability to render services when Provider and patient are in separate locations.

A. Asynchronous Telehealth Services – the transmission of a patient's pre-recorded medical information from an originating site to the Provider at a distant site without the patient being present.

B. Synchronous Telehealth Services – the interaction between patient and Provider in different locations in real time, by means of two-way video and audio transmission, usually through an established patient portal.

Temporary Employee – An Employee who is employed for 120 consecutive calendar days or less.

Temporomandibular/Craniomandibular Joint Disorder – Disorders resulting in pain and/or dysfunction of the temporomandibular/craniomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes.

Therapeutic/Treatment Vaccine – A vaccine intended to treat infection or disease by stimulating the immune system to provide protection against the infection or disease.

Transplant Acquisition Expense – A donor's medical expenses, for each transplant covered under this Plan.

Urgent Care – A sudden, acute and unexpected medical condition that requires timely diagnosis and treatment but does not pose an immediate threat to life or limb. Examples of Urgent Care include, but are not limited to: colds and flu, sprains, stomach aches, and nausea. Urgent Care may be accessed from an Urgent Care Center that is in the network if a Plan Participant requires non-emergency medical care or a Plan Participant requires Urgent Care after normal business hours of a Plan Participant's Physician.

Urgent Care Center – A clinic with extended office hours that provides Urgent Care and minor Emergency Care to patients on an unscheduled basis without need for appointment. The Urgent Care Center does not provide routine follow-up care or wellness examinations and refers patients back to their regular Physician for such routine follow-up and wellness care.

Utilization Management – Evaluation of necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities.

Utilization Review Organization (URO) - An entity that has established one or more utilization review programs, which evaluates the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures, and facilities; sometimes referred to as Utilization Management.

Value-Based Program (VBP) – An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Well Baby Care – Routine examinations of an infant under the age of twenty-four (24) months for whom no diagnosis is made.

ARTICLE III. SCHEDULE OF ELIGIBILITY

Eligibility requirements for the OGB health plans apply to all participants in OGB-sponsored health plans and the OGB life insurance plan.

THE PLAN ADMINISTRATOR HAS FULL DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR COVERAGE/BENEFITS AND/OR TO CONSTRUE THE TERMS OF THIS PLAN.

NOTE: A Temporary Employee does not meet the Eligibility Requirements under this Benefit Plan, unless such Temporary Employee is determined to be a FTE.

A. Persons to be Covered

1. Employee

   a. A full-time Employee as defined by a Participant Employer and any FTE, both as determined in accordance with applicable state and federal law.

   b. Spouse, Both Employees/Retirees - NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE/RETIREE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE/RETIREE. If a covered Spouse is eligible for coverage as an Employee/Retiree and chooses to be covered separately at a later date, that person will be a covered Employee/Retiree effective the first day of the month after the election of separate coverage. The change in coverage will not increase Benefits.

   c. Effective Dates of Coverage, New Employee, Transferring Employee, and FTE

      Coverage for each Employee who completes the applicable enrollment form and agrees to make the required payroll contributions to his Participant Employer is effective as follows:

      (1) For new full-time Employees, if employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if hired on July 1st, coverage will begin on August 1st).

      (2) For new full-time Employees, if employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15th, coverage will begin on September 1st).

      (3) Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

      (4) An Employee who transfers employment to another Participant Employer must complete a transfer form within thirty (30) days following the date of transfer to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

      (5) An Employee who is determined to be a FTE will be allowed to enroll in the Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth month of employment for those Employees determined to be FTEs during their initial measurement period.

(6) Employee coverage will become effective concurrent with the date employment begins when required by state law during a federal or state declaration of emergency involving risk to health of individuals employed by a public elementary or secondary school system.

d. Re-Enrollment for Health and/or Life Benefits

(1) Full-time Employees returning to full time or part-time status with less than thirteen (13) weeks (less than 26 weeks for educational institutions) since separation or termination may resume coverage if application is made within thirty (30) days following return to work. Coverage will resume on the first of the month following return to work.

(2) If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within thirty (30) days of re-employment.

e. Board and Commission Members

Except as otherwise provided by law, board and commission members are not eligible to participate in this Plan. This provision does not apply to members of school boards, state boards, or commissions as defined by the Participant Employer as full-time Employees.

f. Legislative Assistants

A legislative assistant is eligible to participate in the Plan if he or she is determined to be a full-time Employee by the Participant Employer under applicable federal and state law or pursuant to La.R.S. 24:31.5(C), and either:

- Receives at least sixty (60) percent of the total compensation available to employ the legislative assistant if the legislator Employer employs only one legislative assistant; or

- Is the primary legislative assistant as defined in La.R.S. 24:31.5(C) when a legislator Employer employs more than one legislative assistant.

2. Retiree Coverage-Eligibility

a. Retirees of Participant Employers are eligible for Retiree coverage under this Plan.

b. Retirees of Participant Employers may not be covered as an Employee.

c. Effective Date of Coverage - Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions. For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. For example, if date of retirement is July 15, retiree coverage will begin August 1; if date of retirement is August 1, retiree coverage will begin September 1.

3. Documented Dependent Coverage - Eligibility

a. Documented Dependent of an eligible Employee/Retiree will be eligible for Dependent coverage on the latest of the following dates:

(1) The date the Employee/Retiree becomes eligible;

(2) The Date Acquired for Employee's/Retiree's Dependents

b. Effective Dates of Coverage – Application for coverage must be made within thirty (30) days of eligibility for coverage.

(1) Documented Dependents of Employees/Retirees - Coverage will be effective on the Date Acquired.

c. NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE/RETIREE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE/RETIREE.

4. HIPAA Special Enrollment Events

Certain eligible persons may enroll in the Plan if they experience a HIPAA Special Enrollment Event as provided by federal law. HIPAA Special Enrollment Events include but are not limited to birth, adoption, placement for adoption, marriage, eligibility for premium assistance subsidy under Medicaid or State Children's Health Insurance Program (SCHIP) coverage, loss of other health coverage through divorce, legal separation, or annulment, and loss of eligibility based on termination of Medicaid or SCHIP coverage. Application to the Plan Administrator must be made within thirty (30) days of the HIPAA special enrollment event unless a longer period is provided by federal law or by OGB.

5. Other Special Enrollment or Disenrollment Events

Employees/Retirees may also change coverage outside of Annual Enrollment if they or an applicable eligible dependent experience an OGB Plan-Recognized Qualified Life Event that allows for a specific change in coverage and make timely application to the Plan Administrator for such. The OGB Plan-Recognized Qualified Life Events are subject to change at any time and can be found at **http://info.groupbenefits.org/qle/**.

6. Medicare Advantage Option for Retirees other than OGB-sponsored plans

Retirees who are eligible to participate in a Medicare Advantage plan sponsored by OGB who cancel coverage with the Plan upon enrollment in such a Medicare Advantage plan may re-enroll in the Plan upon withdrawal from or termination of coverage in the Medicare Advantage plan, during the next Annual Enrollment, for coverage effective at the beginning of the next Plan Year.

Retirees who elect to participate in a Medicare Advantage plan not sponsored by OGB will not be allowed to reenroll in a plan offered by OGB upon withdrawal from or termination of coverage in the Medicare Advantage plan.

7. TRICARE for Life Option for Military Retirees

Retirees eligible to participate in the TRICARE for Life (TFL) option on and after October 1, 2001, who cancel coverage with the Plan upon enrollment in TFL may re-enroll in the Plan in the event that the TFL option is discontinued or its Benefits significantly reduced.

B. Continued Coverage

1. Leave of Absence

a. Leave of Absence without Pay, Employer Contributions to Premiums

(1) A participating Employee who is granted leave of absence without pay due to a service related injury may continue coverage and the Participant Employer shall continue to pay its portion of health plan premiums for up to twelve (12) months if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

(2) A participating Employee who suffers a service related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the Participant Employer shall continue to pay its portion of the

premium until the Employee becomes gainfully employed or is placed on state disability retirement.

(3) A participating Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the Participant Employer shall continue to pay its portion of premiums if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

b. Leave of Absence Without Pay - No Employer Contributions to Premiums

An Employee granted leave of absence without pay for reasons other than those stated in above in B.1., may continue to participate in an OGB Plan for a period up to twelve (12) months upon the Employee's payment of the full premiums due.

THE PARTICIPANT EMPLOYER AND THE EMPLOYEE MUST NOTIFY THE PLAN ADMINISTRATOR WITHIN THIRTY (30) DAYS OF THE EFFECTIVE DATE OF THE LEAVE OF ABSENCE.

2. Disability

a. Employees who have been granted a waiver of premium for Basic or Supplemental Life Insurance prior to July 1, 1984, may continue health coverage for the duration of the waiver if the Employee pays the total contribution to the Participant Employer. Disability waivers were discontinued effective July 1, 1984.

b. If a Participant Employer withdraws from the Plan, health and life coverage for all Covered Persons will terminate on the effective date of withdrawal.

3. Surviving Dependents/Spouse

a. Benefits under the Plan for covered Dependents of a deceased covered Employee/Retiree will terminate on the last day of the month in which the Employee's/Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

(1) The surviving Spouse of an Employee/Retiree may continue coverage unless or until the surviving Spouse is or becomes eligible for coverage in a group health plan other than Medicare.

(2) The surviving Dependent Child of an Employee/Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a group health plan other than Medicare or until end of the month of the attainment of the termination age for that specific Dependent Child, whichever occurs first.

(3) Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees/Retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits.

(4) Coverage provided by the Civilian Health and Medical Program for the Uniform Services (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving Spouse or a Dependent Child.

b. A surviving Spouse or Dependent cannot add new Dependents to continued coverage other than a Child of the deceased Employee/Retiree born after the Employee's/Retiree's death.

c. Participant Employer/Dependent Responsibilities

(1) The Participant Employer and/or surviving covered Dependent shall notify the Plan Administrator within thirty (30) days of the death of the Employee.

(2) The Plan Administrator will notify the surviving Dependents of their right to continue coverage.

(3) Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of notification, and premium payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.

(4) Coverage for the surviving Spouse under this section will continue until the earliest of the following:

(a) Failure to pay the applicable premiums, contributions and surcharges timely.

(b) Eligibility of the surviving Spouse under a group health plan other than Medicare.

(5) Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:

(a) Failure to pay the applicable premiums, contributions and surcharges timely.

(b) Eligibility of the surviving Dependent Child for coverage under any group health plan other than Medicare; or

(c) The end of the month of attainment of the termination age for that specific Dependent Child.

d. The provisions of paragraphs 3.a. through 3.c. above are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree.

Continued coverage for surviving Dependents that made such election before July 1, 1999, shall be governed by the rules in effect at the time of the election.

4. Over-Age Dependents

If a Dependent Child is incapable (and became incapable prior to attainment of age twenty-six (26) of self-sustaining employment, by reason of physical or mental disability, the coverage for the Dependent Child may be continued for the duration of incapacity.

a. No earlier than six (6) months prior to the Dependent Child reaching age twenty-six (26), an application for continued coverage must be filed with the Plan Administrator on a form designated by the Plan Administrator, with current medical information from the Dependent Child's attending Physician along with the Child's attending Physician's attestation of the Child's incapacity to perform self-sustaining employment, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.

b. After the initial approval, the Plan Administrator may require the submission of additional medical or other supporting documentation substantiating the continuance of the disability, but not more frequently than annually, as a precondition to continued coverage.

5. Military Leave

Employees of the National Guard or in the United States military reserves who are called to active

military duty and their covered eligible Dependents will have access to continued coverage under OGB's health and life plans subject to submittal of appropriate documentation to OGB.

a. Health Plan Participation - When an Employee is called to active military duty, the Employee and his/her covered eligible Dependents may:

(1) continue participation in the health plan during the period of active military service, in which case the Participant Employer may continue to pay its portion of premiums; or

(2) cancel participation in the health plan during the period of active military service, in which case the Employee may apply for reinstatement of OGB coverage within thirty (30) days of:

(a) the date of the Employee's re-employment with a Participant Employer; or

(b) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Employees who elect this option and timely apply for reinstatement of OGB coverage, the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding rules promulgated by OGB.

C. COBRA

1. Employees

a. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

b. The Participant Employer shall notify the Plan Administrator within thirty (30) days of the date coverage would have terminated because of any of the foregoing events. OGB's third-party COBRA vendor ("COBRA Administrator") will notify the Employee within fourteen (14) days of such notification of his right to continue coverage.

c. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification, and premium payment must be made to the COBRA Administrator within forty-five (45) days of the date the Employee elects continued coverage. Continued Coverage will be retroactive to the date it would have otherwise terminated.

d. Coverage under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Eighteen (18) months from the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a Group Health Plan; or

(5) The Employer ceases to provide any group health plan for its Employees/Retirees.

e. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered

Spouse and/or covered Dependent Children may elect to continue coverage at his own expense. The elected coverage will be subject to the above stated notification and termination provisions.

2. Surviving Dependents

   a. Coverage under this Plan for covered surviving Dependents of an Employee/Retiree will terminate on the last day of the month in which the Employee's/Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.

   b. The Participant Employer and/or surviving covered Dependents shall notify the Plan Administrator within thirty (30) days of the death of the Employee. The COBRA Administrator will notify the surviving Dependents of their right to continue coverage within 14 days of receipt of such notification. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification.

   c. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

   d. Coverage for the surviving Dependents under this section will continue until the earliest of the following:

      (1) Failure to pay the applicable premiums, contributions and surcharges timely;

      (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

      (3) Entitlement to Medicare;

      (4) Coverage under a Group Health Plan; or

      (5) The Employer ceases to provide any group health plan for its Employees.

3. Ex-Spouse/Ex-Stepchildren - Divorce, Annulment, Legal Separation or Death

   a. Coverage under this Plan for an Employee's/Retiree's Spouse (and any stepchildren enrolled on the Plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment, or legal separation from the Employee/Retiree, unless the covered ex-Spouse elects to continue coverage at his/her own expense.

   b. Coverage under this Plan for an Employee's/Retiree's stepchild will terminate on the last day of the month of the death of the Employee's/Retiree's Spouse who is the stepchild's parent.

   c. The Employee/Retiree or the ex-spouse/ex-stepchild shall notify the Plan Administrator of the divorce, annulment, legal separation or death within sixty (60) days from the date of the divorce, annulment, legal separation or death. The COBRA Administrator will notify the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) within fourteen (14) days of his/her/their right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the election notification.

   d. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of

the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

e. Coverage for the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

4. Dependent Children

a. Coverage under this plan for a covered Dependent Child will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent Child elects to continue coverage at his own expense.

b. The Dependent Child shall notify the Plan Administrator of his loss of eligibility within sixty (60) days of the date coverage would have terminated. The COBRA Administrator will notify the Dependent Child within fourteen (14) days of his/her right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of receipt of the election notification.

c. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for a Dependent Child under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

5. Dependents of COBRA Participants

a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered Spouse or a covered Dependent Child becomes ineligible for coverage due to:

(1) Death of the Employee,

(2) Divorce, Annulment, or Legal Separation from the Employee, or

(3) A Dependent Child no longer meets the definition of an eligible covered Dependent, then, the Spouse and/or Dependent Child may elect to continue COBRA coverage at his/her own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

b. The Spouse and/or the Dependent Child shall notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.

c. Monthly payments to the COBRA Administrator for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for the Spouse or Dependent Child under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a Group Health Plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

6. Disability COBRA

a. If a Plan Participant is determined by the Social Security Administration or by the COBRA Administrator staff (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient quarters of employment) to have been totally disabled on the date the Plan Participant became eligible for continued coverage or within the initial eighteen (18) months of continued coverage, coverage under this Plan may be extended at his own expense up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated.

b. To qualify for disability COBRA, the Plan Participant must:

(1) Submit a copy of his/her Social Security Administration's disability determination to the COBRA Administrator before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:

(a) The date of issuance of the Social Security Administration's disability determination; and

(b) The date on which the qualified beneficiary loses (or would lose) coverage under terms of the Plan as a result of the covered Employee's termination or reduction of hours.

(2) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of employment, submit proof of total disability to the COBRA Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the COBRA Administrator will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.

c. For purposes of eligibility for extended continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of twelve (12) months.

To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

d. Monthly payments to the COBRA Administrator for each month of extended disability COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

e. Coverage under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Twenty-nine (29) months from the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan;

(5) The Employer ceases to provide any group health plan for its Employees; or

(6) Thirty (30) days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Plan Administrator and the COBRA Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the COBRA Administrator determines that the Covered Person is no longer disabled.

7. Medicare COBRA

a. If an Employee becomes entitled to Medicare less than eighteen (18) months before the date the Employee's eligibility for Benefits under this Plan terminates, the period of continued coverage available for the Employee's covered Dependents will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months from the date of the Employee's Medicare entitlement;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

b. Monthly payments to the COBRA Administrator for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

8. Miscellaneous Provisions

When the Employee/Retiree will participate in COBRA continuation coverage with his/her Dependents which are qualified beneficiaries, the Employee/Retiree and those Dependents that elect COBRA will continue the same HRA Account that they had when the Employee/Retiree was active.

When the Employee/Retiree will not participate in COBRA continuation coverage with his/her Dependents, the qualified beneficiaries that elect COBRA will be set up in a separate HRA Account until the end of their continuation coverage. Such separate HRA Account will have its own Accrual based on enrollment status, and its own Carryover features. HRA Accounts set for these qualified beneficiaries will not carryover any portion of the Available Amount from the original HRA Account.

Otherwise, during the period of continuation of coverage, Benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Plan Participants.

D. Change of Classification

1. Adding or Deleting Dependents

   When a Dependent is added to the Employee's/Retiree's coverage as a result of a HIPAA Special Enrollment Event or deleted from the Employee's/Retiree's coverage consistent with a change in status, application made by an active Employee shall be provided to the Employee's Human Resources liaison and application made by a Retiree shall be provided to OGB. Application is required to be made within thirty (30) days of the HIPAA Special Enrollment Event or change in status unless otherwise specified in this Plan document or unless a longer application period is required by federal or state law. When a Dependent is added to or deleted from coverage during an OGB-designated enrollment period, application is required to be made as directed by OGB for the designated enrollment period.

2. Change in Coverage

   When the addition of a Dependent as a result of a HIPAA Special Enrollment Event results in a change in classification, the change in classification will be effective on the date of the HIPAA Special Enrollment Event.

3. Notification of Change

   It is the Employee/Retiree's responsibility to make application for any change in classification of coverage.

E. Contributions

The State of Louisiana may make a contribution toward the cost of the Plan, as determined by the Legislature.

F. Medical Child Support Orders

A Dependent Child shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). Application must be made within thirty (30) days of the receipt of the QMCSO or NMSN. Coverage will be effective the first of the month following OGB's receipt of timely application and all required supporting documentation. An Employee who is not currently enrolled in an OGB Plan may enroll to effect coverage for his or her Dependent(s) who are the subject of the QMCSO.

A QMCSO is a state court order or judgment, including approval of a settlement agreement that:

1. Provides for support of a covered Plan Participant's Dependent Child;

2. Provides for healthcare coverage for that Dependent Child;

3. Is made under state domestic relations law (including a community property law);

4. Relates to Benefits under the Plan; and

5. Is “qualified” in that it meets the technical requirements of applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the Dependent Child of a non-custodial parent who is (or will become) a Covered Person by a domestic relations order that provides for healthcare coverage.

G. Termination of Coverage

Subject to continuation of coverage and COBRA rules, all benefits of a Plan Participant will terminate under this Plan on the earliest of the following dates:

1. The date the Plan terminates;

2. The date the Participant Employer terminates or withdraws from the Plan;

3. The date contribution is due if the Participant Employer fails to pay the required contribution;

4. The date contribution is due if the Plan Participant fails to make any contribution which is required for the continuation of coverage;

5. The last day of the month of the Plan Participant’s death;

6. The last day of the month in which the Plan Participant ceases to be eligible as a Plan Participant.

ARTICLE IV. BENEFITS

ANY BENEFIT LISTED IN THIS BENEFIT PLAN, WHICH IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED.

All Eligible Expenses are determined in accordance with Plan Limitations and Exclusions.

A. Benefit Categories

1. If this Benefit Plan includes more than one (1) Plan Participant, the Individual Deductible Amount is not applicable. The Family Deductible Amount applies.

2. If this Benefit Plan includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies.

3. Network and Non-Network Benefit categories may each carry separate Deductibles and Out-of-Pocket Amounts, as shown in the Schedule of Benefits.

    a. Network Benefits (In-Network): Benefits for medical care received from a Network Provider (Providers contracted with the Claims Administrator in the PPO Network). When a Plan Participant receives care from a Network Provider, he will receive the highest level of Benefits on this Plan.

    b. Non-Network Benefits (Out-of-Network): Benefits for medical care received from a Provider who is not contracted with the Claims Administrator in the PPO Network. When a Plan Participant receives care from a Non-Network Provider, he will receive a lower level of Benefits on this Plan.

B. Deductible Amount

1. Subject to the Deductible Amounts, as shown in the Schedule of Benefits, and other terms and provisions of this Benefit Plan, the Claims Administrator will provide Benefits in accordance with the Coinsurance shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period. The following Deductibles may apply to Benefits provided by this Plan. Deductibles will accrue to the Out-of-Pocket Amount.

    a. Individual Deductible Amount: The dollar amount, as shown in the Schedule of Benefits, of Allowable Charges for Covered Services, which a Plan Participant with Employee Only coverage must pay within a Benefit Period before the Plan starts paying Benefits.

    b. Family Deductible Amount: The dollar amount, as shown in the Schedule of Benefits, of Allowable charges for Covered Services, which must be paid by a family within a Benefit Period before the Plan starts paying Benefits. No Benefits are eligible for payment on any covered member of the family until the total Family Deductible Amount has been met. After the Family Deductible Amount is met, the Plan starts paying Benefits for all covered members of the family, for the remainder of the Benefit Period.

    c. For the purposes of this Benefit Plan, “Family” includes all available classes of coverage except single Employee or Employee Only coverage.

    d. When a Child is born to a Plan Participant having Employee Only coverage, the Child is granted 30 days of automatic coverage on the Benefit Plan from the date of birth and the Deductible will increase from an Individual Deductible to a Family Deductible.

    e. The Plan will apply the Plan Participant's Eligible Expenses to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's

Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by the Claims Administrator. The Claims Administrator's records will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays his Deductible Amount, the Plan Participant is entitled to receive a refund from the Provider in which the overpayment was made.

2. If the Plan pays the Provider amounts that are the Plan Participant's responsibility, such as Deductibles or Coinsurance, the Claims Administrator may collect such amounts directly from the Plan Participant. The Plan Participant agrees that the Claims Administrator has the right to collect such amounts.

C. Coinsurance

The Coinsurance percentage is shown on the Schedule of Benefits for a Covered Service. The Plan Participant must first pay any applicable Deductible Amount before the Coinsurance percentage. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Plan will provide Benefits based on the Coinsurance percentages shown in the Schedule of Benefits toward Allowable Charges for Covered Services. The actual payment to a Provider or payment to the Plan Participant satisfies the Plan Sponsor's obligation to provide Benefits under this Benefit Plan.

D. Out-of-Pocket Amount

1. Individual Out-of-Pocket Amount: The maximum amount, as shown in the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amount and Coinsurance), which may be paid by a Plan Participant with Employee Only coverage, within a Benefit Period. After the Individual Out-of-Pocket is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Covered Services, for the remainder of the Benefit Period.

2. Family Out-of-Pocket Amount: The maximum amount, as shown in the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amounts and Coinsurance), which may be paid by a family within a Benefit Period. If the Benefit Plan covers more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Covered Services, for all covered members of the family, for the remainder of the Benefit Period, whether each member has met the Per Member within a Family Out-of-Pocket Amount.

3. Per Member within a Family Out-of-Pocket Amount: The maximum dollar amount, as shown in the Schedule of Benefits, of non-reimbursable expenses for Network Covered Services, which may be paid by one (1) family member within a Benefit Period. After the Per Member within a Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Network Covered Services, for that family member, for the remainder of the Benefit Period. No family member may contribute more than the Per Member within a Family Out-of-Pocket Amount towards satisfaction of the Family Out-of-Pocket Amount.

4. The following accrue to the Out-of-Pocket Amount:

    a. Deductible Amounts;

    b. Coinsurance; and

    c. Copayments.

5. The following do not accrue to the Out-of-Pocket Amount:

   a. any charges in excess of the Allowable Charge;

   b. any penalties the Plan Participant or Provider must pay; and

   c. any charges for non-Covered Health Services.

6. Eligible Expenses for services of a Network Provider that are applied to the Out-of-Pocket Amount for Network Providers will not apply toward the Out-of-Pocket Amount for Non-Network Providers.

   Eligible Expenses for services of a Non-Network Provider that apply toward the Out-of-Pocket Amount for Non-Network Providers will not apply toward the Out-of-Pocket Amount for Network Providers.

   When the Out-of-Pocket Amount, as shown above, has been satisfied, this Plan will pay 100% of the Allowable Charge toward Eligible Expenses for the remainder of the Plan Year.

E. Accumulator Transfers

If necessitated as a direct result of a HIPAA Special Enrollment Event or COBRA Qualifying Life Event, Plan Participants may transfer from one of the Group's self-insured Plans to another Group self-insured Plan with the same Claims Administrator. Plan Participant's accumulators may be carried from the old Plan to the new Plan. Accumulators include, but are not limited to, Deductibles, Out-of-Pocket Amounts, or Benefit Period Maximums.

ARTICLE V. HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-emergency, Emergency, Pregnancy Care, Mental Health and Substance Use Disorder Admissions) must be Authorized as outlined in the Care Management Article. In addition, at regular intervals during the Inpatient stay, the Plan will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care. The Plan Participant must pay any Deductible Amount and any Coinsurance as shown in the Schedule of Benefits.

If a Plan Participant receives services from a Physician in a hospital-based clinic, the Plan Participant may be subject to charges from the Physician and/or clinic as well as the facility.

The following services furnished to a Plan Participant by a Hospital are covered:

A. Inpatient Bed, Board and General Nursing Service

1. In a Hospital.

2. In a Special Care Unit, for a critically ill Plan Participant requiring an intensive level of care.

3. In a Skilled Nursing Facility or Unit, or while receiving skilled nursing services in a Hospital or other facility approved by the Claims Administrator. A maximum number of days per Benefit Period may apply if shown in the Schedule of Benefits.

4. In a Residential Treatment Center for Plan Participants with a Mental Health or Substance Use Disorders.

B. Surgical Services (Inpatient and Outpatient)

1. Surgery

   The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by the Plan and is that period of time which is appropriate as routine care for the particular surgical procedure.

2. Multiple Medical or Surgical Services

   When Medically Necessary multiple services (concurrent, successive, or other multiple medical or surgical services) are performed at the same encounter, Eligible Expenses will be paid as follows:

   a. Primary Service

      (1) The primary or major service is determined by the Claims Administrator.

      (2) Benefits for the primary service will be based on the Allowable Charge.

   b. Secondary Service(s)

      The secondary service(s) is a service(s) performed in addition to the primary service as determined by the Claims Administrator. The Allowable Charge for the secondary service will be based on a percentage of the Allowable Charge that would be applied had the secondary service been the primary service.

   c. Incidental Service

      (1) An incidental service is one carried out at the same time as a primary service as determined by the Claims Administrator.

      (2) Covered incidental services(s) are not reimbursed separately. The Allowable Charge for the primary service includes coverage for the incidental service(s). If the primary service is not covered, any incidental service(s) will not be covered.

   d. Unbundled Service(s)

      (1) Unbundling occurs when two (2) or more service codes are used to describe a medical or surgical service performed when a single, more comprehensive service code exists that accurately describes the entire medical or surgical service performed. The unbundled services are considered included in the proper comprehensive service code as determined by the Claims Administrator.

      (2) The Allowable Charge of the comprehensive code includes the charge for the unbundled services. The Plan will provide Benefits according to the proper comprehensive service code, as determined by the Claims Administrator.

   e. Mutually Exclusive Service(s)

      (1) Mutually exclusive services are two (2) or more services that usually are not performed at the same operative session or encounter on the same patient on the same date of service. Mutually exclusive services may also include different service code descriptions for the same type of services in which the Physician should be submitting only one (1) of the codes. One or more of the duplicative services is not reimbursable as it should be reimbursed only one time.

(2) The Allowable Charge includes all services performed at the same encounter. Any and all service(s) which are not considered Medically Necessary will not be covered.

3. Assistant Surgeon

An assistant surgeon is a Physician, licensed physician assistant, certified registered nurse first assistant (CRNFA), registered nurse first assistant (RNFA), or certified nurse practitioner. Coverage for an assistant surgeon is provided only if the use of an assistant surgeon is required with reference to nationally established guidelines. The Allowable Charge for the assistant surgeon is based on a percentage of the fee paid to the primary surgeon.

4. Anesthesia

a. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined the Plan and approved by the Claims Administrator. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.

b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless the Claims Administrator determines otherwise.

c. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

C. Other Hospital Services (Inpatient and Outpatient)

Benefits are available for the following services, drugs, supplies, and devices, when performed, prescribed, or ordered by a Physician and Medically Necessary for the Treatment of a Plan Participant.

1. Hospital Care includes the medical services, supplies, treatments, drugs, and devices furnished by a hospital or Ambulatory Surgical Center.

2. Use of operating, delivery, recovery and treatment rooms and equipment;

3. Drugs and medicines including take-home Prescription Drugs

4. Covered Services of a Physician;

5. Routine Nursing Services, i.e., “floor nursing” services provided by nurses employed by the hospital are considered as part of the room and board;

6. Diagnostic testing, including, but not limited to, laboratory services and Low-Tech Imaging;

7. Nuclear medicine and electroshock therapy;

8. Blood, blood derivatives, and blood processing, when not replaced;

9. Surgical and medical supplies billed for treatment received in a Hospital or Ambulatory Surgical Center.

10. Intravenous injections, solutions, and related intravenous supplies;

11. Physical Therapy provided by a Hospital employee;

12. Psychological testing ordered by the attending Physician and performed by a Hospital employee.

D. Emergency Room

Benefits are available for Emergency Medical Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. If the Plan Participant receives treatment from a Non-Network facility and the Plan Participant's condition is an Emergency as defined in the Definitions Article of this Benefit Plan, Benefits will be paid at the Network level.

E. Pre-Admission Testing

Benefits will be provided for the Outpatient facility charge and associated professional fees for Diagnostic Services rendered within seventy-two (72) hours of a scheduled procedure performed at an Inpatient or Outpatient Facility.

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

Benefits for the following medical and surgical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. A Plan Participant must pay any applicable Deductible Amounts and Coinsurance shown in the Schedule of Benefits.

A. Surgical Services

1. Surgery

   a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by the Plan and is that period of time which is appropriate as routine care for the particular surgical procedure.

   b. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefit Payment is allowed toward charges for office visits on the same day as the Surgery.

2. Multiple Medical or Surgical Services - When Medically Necessary multiple services (concurrent, successive, or other multiple medical or surgical services) are performed at the same encounter, Eligible Expenses will be paid as follows:

   a. Primary Service

      (1) The primary or major service is determined by the Claims Administrator.

      (2) Benefit Payment for the primary service will be based on the Allowable Charge.

   b. Secondary Service(s)

      The secondary service(s) is a service(s) performed in addition to the primary service as determined by the Claims Administrator. The Allowable Charge for the secondary service will be based on a percentage of the Allowable Charge that would be applied had the secondary service been the primary service.

c. Incidental Service

(1) An incidental service is one carried out at the same time as primary service as determined by the Claims Administrator.

(2) Covered incidental service(s) are reimbursed separately. The Allowable Charge for the primary service includes coverage for the incidental service(s). If the primary service is not covered, any incidental service(s) will not be covered.

d. Unbundled Service(s)

(1) Unbundling occurs when two (2) or more service codes are used to describe medical or surgical service performed when a single, more comprehensive service code exists that accurately describes the entire medical or surgical service performed. The unbundled services are considered included in the proper comprehensive service code as determined by the Claims Administrator.

(2) The Allowable Charge of the comprehensive code includes the charge for the unbundled services. The Plan will provide Benefits according to the proper comprehensive service code, as determined by the Claims Administrator.

e. Mutually Exclusive Service(s)

(1) Mutually exclusive services are two (2) or more services that usually are not performed at the same operative session or encounter on the same patient on the same date of service. Mutually exclusive services may also include different service code descriptions for the same type of services in which the Physician should be submitting only one (1) of the codes. One or more of the duplicative services is not reimbursable as it should be reimbursed only one time.

(2) The Allowable Charge includes all services performed at the same encounter. Any and all service(s) which are not considered Medically Necessary will not be covered.

3. Assistant Surgeon

An assistant surgeon is a Physician, licensed physician assistant, certified registered nurse first assistant (CRNFA), registered nurse first assistant (RNFA) or certified nurse practitioner. Coverage for an assistant surgeon is provided only if the use of an assistant surgeon is required with reference to nationally established guidelines. The Allowable Charge for the assistant surgeon is based on a percentage of the fee paid to the primary surgeon.

4. Anesthesia

a. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services.

Coverage is also provided for other forms of anesthesia services as defined and approved by the Plan. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.

b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless the Plan determines otherwise.

c. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs

or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

5. Second Surgical Opinion

   Benefits will be provided for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. Second or third opinion consultant must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory in order to receive Benefits.

B. Inpatient Medical Services

Subject to provisions in the sections for Surgery and Pregnancy Care and Inpatient Medical Services include:

1. Inpatient medical care visits.

2. Concurrent Care.

3. Consultation (as defined in this Benefit Plan).

C. Outpatient Medical Services and Surgical Services

1. Home, office, and other Outpatient visits for examination, diagnosis, and treatment of an illness or injury. Benefits for Outpatient medical services do not include separate payments for routine pre-operative and post-operative medical visits for Surgery or Pregnancy Care.

2. Consultation (as defined in this Benefit Plan).

3. Diagnostic Services.

4. Services of an Ambulatory Surgical Center.

5. Services of an Urgent Care Center.

6. Medically necessary/non-Investigational Prescription Drugs requiring parenteral administration in a Physician's Office are payable under this medical Benefit.

7. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician's office are payable under this medical Benefit.

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

Blue Cross and Blue Shield of Louisiana does not provide claims payment services for drugs purchased at a pharmacy. These drugs and others are payable under the Pharmacy Benefits that are provided by OGB's Pharmacy Benefit Manager. Each Plan Participant acknowledges and accepts the Pharmacy Benefit Manager designated by OGB from time to time and agrees to receive communications from the Pharmacy Benefit Manager for purpose of administering any OGB Pharmacy benefits or prescription drug program. See the Schedule of Benefits for more information.

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to a Plan Participant upon the effective date required for the coverage. If a Plan Participant receives Preventive or Wellness Care services from a Network or Non-Network Provider, the services will be paid at one hundred percent (100%) of the Allowable Charge. The Deductible Amount will not apply to Covered Services received for Preventive or Wellness Care. Preventive or Wellness Care services may be subject to other limitations shown in the Schedule of Benefits.

A. Well Woman Examinations (Benefit Period Deductible does not apply)

1. Visits to an obstetrician/gynecologist for recommended covered Preventive or Wellness Care services. Additional visits recommended by the Plan Participant's obstetrician/gynecologist for services other than covered Prevention or Wellness Care may be subject to the Deductible Amount or Coinsurance percentage shown in the Schedule of Benefits.

2. One (1) routine Pap smear per Benefit Period.

3. One (1) mammography examination, including breast ultrasound per Benefit Period. For Plan Participants ages 40 - 49, a mammography examination, including breast ultrasound may be conducted more frequently if recommended by a Physician. Any additional mammography examinations recommended by the Plan Participant's Physician may be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. A breast ultrasound may be completed alone or in conjunction with a mammogram.

B. Physical Examinations and Testing (Benefit Period Deductible does not apply)

1. Routine Wellness Physical Exam – Certain routine wellness diagnostic tests ordered by Your Physician are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Care Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels.

   High-Tech Imaging such as an MRI, MRA, CT scan, PET scan, and nuclear cardiology are not covered under this Preventive or Wellness Care Benefit. These High-Tech Imaging services are subject to Deductible Amount and Coinsurance percentage when the tests are Medically Necessary.

2. Well Baby Care – Routine examinations will be covered for infants under the age of 24 months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the Routine Wellness Physical Exam Benefit.

3. Prostate Cancer Screening – One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, is covered for Plan Participants fifty (50) years of age or older, and as recommended by his Physician if the Plan Participant is over forty (40) years of age.

   An additional visit shall be permitted if recommended by the Plan Participant's Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits.

4. Colorectal Cancer Screening – a FIT (Fecal Immunochemical Test) for blood, Cologuard (FIT-fecal) DNA testing, Computed Tomographic (CT) colonography, flexible sigmoidoscopy, or colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

   Selected generic Physician prescribed colonoscopy preparations and supplies for colonoscopies covered under the Preventive and Wellness Benefit will be covered at first dollar when obtained from

a Network Pharmacy in the OGB Self-Insured Plan Pharmacy Benefit Manager's Network. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Plan Participant only under the following circumstances: Physician prescribes brand-name colonoscopy preparation and supplies because of Plan Participant's inability to tolerate selected generic colonoscopy preparation and supplies.

5. Bone Mass Measurement – scientifically proven tests for the diagnosis and treatment of osteoporosis if a Plan Participant is:

   a. an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;

   b. an individual receiving long-term steroid therapy; or

   c. an individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.

   One (1) osteoporosis screening, per Benefit Period, is available at no cost to the Plan Participant, for women age 65 and older, one (1) every 2 years for younger postmenopausal women at risk, when care is received from a Network Provider.

6. BRCA1 and BRCA2 Genetic Testing – Genetic testing of BRCA1 and BRCA2 genes will be covered at no cost to You when obtained from a Network Provider to detect an increased risk of breast and ovarian cancer when recommended by a healthcare provider in accordance with the United States Preventive Services Task Force recommendations.

C. Immunizations (Benefit Period Deductible does not apply)

Immunizations, including, but not limited to, seasonal flu immunizations, as recommended by the Plan Participant's Physician or required by law.

D. COVID-19 Services

Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by a Plan Participant's Physician for the purpose of making clinical decisions or treating a Plan Participant suspected of having COVID-19 are covered under this Plan. When a Plan Participant receives these services from a Network or Non-Network Provider, Benefits will be covered, up to the Network allowable, at no cost until December 31, 2021, or as required by applicable federal law. Non-Network Providers may balance bill the Plan Participant up to their full-billed charge. Balance bills do not apply to the Out-of-Pocket Maximum. After December 31, 2021, this Plan may pay according to the Contract Benefits, subject to applicable Copayments, Deductibles, and Coinsurance Amounts, as shown on the Schedule of Benefits for Network or Non-Network Providers.

The approved diagnostic tests and antibody tests do not include a test used for employment-related or public health surveillance testing and, regardless of medical necessity, any COVID-19 diagnostic tests or antibody tests for those purposes are excluded from coverage.

E. Preventive or Wellness Care Required by the Patient Protection and Affordable Care Act

Services recommended by the United States Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

The list of covered services changes from time to time. To check the current list of recommended Preventive or Wellness Care services required by PPACA, visit the United States Department of Health and Human Services' website at: **http://www.healthcare.gov/preventive-care-benefits** or contact Our Customer Service Department at the telephone number on Your ID card.

F. New Recommended Preventive or Wellness Care Services

New services are covered by this Benefit Plan on the date required by law for such coverage.

ARTICLE IX. MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

A. Treatment of Mental Health is covered. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treatment of Mental Health do not include counseling services such as career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling.

B. Plan Participants who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis when the Claims Administrator Authorizes it for treatment of Autism Spectrum Disorders. Applied Behavior Analysis must be rendered by an appropriately licensed behavior analyst or certified assistant behavior analyst.

C. Benefits for treatment of Substance Use Disorders are available. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.

Refer to the Schedule of Benefits for more information on Mental Health and Substance Use Disorder Benefits.

ARTICLE X. ORAL SURGERY AND DENTAL SERVICES

A. Surgical Services

Benefits are available for the following oral and maxillofacial surgeries:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;

2. External incision and drainage of cellulitis;

3. Incision of accessory sinuses, salivary glands or ducts;

4. Frenectomy (the cutting of the tissue in the midline of the tongue);

5. Reduction of fractures and dislocations of the jaw.

The highest level of Benefits is available when services are performed by a Network Provider, or by a Provider in Blue Cross and Blue Shield of Louisiana's dental network. Access the dental network online at **www.bcbsla.com/ogb** or call the Customer Service telephone number on the Your ID card for a copy of the directory.

B. Dental Services

1. Dental exams and x-rays needed to diagnose impacted teeth are NOT covered. Once diagnosed, removal and any pre-op and post-op care associated with the removal of the impacted teeth are covered.

2. Dental Care and Treatment, including Surgery, and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. Services

must begin within ninety (90) days of the accidental injury and be completed within twenty-four (24) months after the date of injury.

3. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required to restore bodily function for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth.

   The highest level of Benefits is available when services are performed by a Network Provider, or by a Provider in Blue Cross and Blue Shield of Louisiana's dental network. Access the dental network online at **www.bcbsla.com/ogb** or call the Customer Service telephone number on the Your ID card for a copy of the directory.

C. Anesthesia Services

1. Anesthesia for the above services or procedures when rendered by an oral surgeon.

2. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.

3. Anesthesia when rendered in a Hospital or Outpatient facility setting and for associated Hospital charges when a Plan Participant's mental or physical condition requires dental treatment to be rendered in a Hospital or Outpatient facility setting.

ARTICLE XI. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

The Claims Administrator's Authorization is required for the evaluation of a Plan Participant's suitability for all solid organ and bone marrow transplants and procedures. For the purposes of coverage under the Plan, all autologous procedures are considered transplants.

Solid organ and bone marrow transplants will not be covered unless the Plan Participant obtains written Authorization from the Claims Administrator prior to services being rendered. The Plan Participant or his Provider must advise the Claims Administrator of the proposed transplant procedure prior to Admission and a written request for Authorization must be filed with the Claims Administrator. The Claims Administrator must receive adequate information to verify coverage, determine that the procedure is Medical Necessary, and approve the site at which the transplant procedure will occur. The Claims Administrator will forward written Authorization to the Plan Participant and to the Provider(s).

A. Acquisition Expenses

Except for bone marrow transplants, donor costs are not payable under this Benefit Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for Bone Marrow transplant procedures will include costs associated with the donor- patient to the same extent and limitations associated with the Covered Person, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

If any organ, tissue or bone marrow is sold rather than donated to a Plan Participant, the purchase price of such organ, tissue or bone marrow is not covered.

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) **for the specific organ or transplant**, or a Blue Cross and Blue Shield of Louisiana (BCBSLA) PPO Network Provider facility, unless otherwise approved by the Claims Administrator and the Plan Administrator in writing.

To locate a BDCT or BCBSLA Network Provider facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their ID card.

2. The Organ, Tissue and Bone Marrow Transplant Benefits are shown in the Schedule of Benefits, and are not covered when services are rendered by a Non-Network Provider.

3. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

4. Benefits as specified in this section will be provided for treatment and care as a result of, or directly related to, the following transplant procedures.

   a. Solid Human Organ Transplants of the:
      (1) liver;

      (2) heart;

      (3) lung;

      (4) kidney;

      (5) pancreas;

      (6) small bowel; and

      (7) other solid organ transplant procedures which the Claims Administrator determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.

   b. Tissue Transplant Procedures (Autologous and Allogeneic)

      Tissue transplants (other than bone marrow) are covered under the Medical and Surgical Benefits Article, and do not require prior Authorization. Evaluation for Tissue Transplant is not required. If an Inpatient Admission is required, it is subject to the Article on Care Management.

      These following tissue transplants are covered:

      (1) blood transfusions;

      (2) autologous parathyroid transplants;

      (3) corneal transplants;

      (4) bone and cartilage grafting;

      (5) skin grafting;

      (6) autologous islet cell transplants; and

      (7) other tissue transplant procedures which the Claims Administrator determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case-by-case basis.

c. Bone Marrow Transplants

(1) Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.

(2) Peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

(3) Other bone marrow transplant procedures which the Claims Administrator determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These bone marrow transplant procedures will be considered on a case-by-case basis.

ARTICLE XII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

Benefits are available for Pregnancy Care furnished by a Hospital, Physician, midwife, or Allied Health Provider to a patient covered as an Employee or Dependent Spouse of an Employee whose coverage is in effect at the time such services are furnished in connection with the Spouse's pregnancy. Pregnancy Care is a covered expense for an Employee or Dependent pregnant Spouse of an Employee only.

Benefits for treatment of ectopic pregnancies and spontaneous abortions are available for all covered Plan Participants under Article V and Article VI of this Benefit Plan the same as any other Covered Service, and are not subject to this Article.

An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn Child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. Authorization must be requested within twenty-four (24) hours of the initial exceedance of the forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a newborn's stay exceeds that of the mother. An Authorization is also required for a newborn that is admitted separately because of neonatal Complications.

To use certain Providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Authorization. For information on Authorization, contact the Claims Administrator.

We have several maternity programs available to help pregnant Plan Participants deliver healthy babies. Please call Our Customer Service Department at the number on the back of Your ID card when You learn You are having a baby. When You call, We'll let You know what programs are available to You.

For Non-Network Benefits, if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described authorization for continued stay must be obtained from the Claims Administrator. If authorization is not obtained, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

A. Pregnancy Care

1. Medical and Surgical Services

    a. Initial office visit and visits during the term of the pregnancy.

    b. Diagnostic Services.

    c. Delivery, including necessary prenatal and postnatal care.

    d. Medically Necessary abortions required to save the life of the mother.

2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for well-baby care is included in the mother's Eligible Expenses for the covered portion of her Admission for Pregnancy Care. As determined by the Claims Administrator, well newborn charges may be covered if the Plan Participant under this Plan is the father.

3. Elective deliveries prior to the thirty-ninth (39^{th}) week of gestation will be denied as not Medically Necessary unless medical records support Medical Necessity. Facility and other charges associated with an elective early delivery that is not Medically Necessary will also be denied.

4. The Family Deductible Amount, as shown in the Schedule of Benefits, applies to all charges when a newborn is added to a Benefit Plan of a Plan Participant holding Employee Only coverage. This amount must be met prior to any Benefits being paid. In addition, coverage for the newborn will be pursuant to the provisions set forth in the Schedule of Eligibility Article of this Benefit Plan.

When a Child is born to a policy having Subscriber only coverage, the Child is granted 30 days of automatic coverage on the policy from the date of birth and the Deductible will increase from an Individual Deductible to a Family Deductible. The Claim for the delivery charges may be applied to the new Family Deductible.

B. Care for a Newborn When Covered at Birth as a Dependent

1. Surgical and medical services rendered by a Physician, for treatment of illness, prematurity, post-maturity, or congenital condition of a newborn and circumcision. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.

2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, prematurity, post-maturity, or congenital condition of a newborn. Charges for services for a well newborn, including the Hospital (nursery) charge should not be billed separately from the mother's Hospital bill. Well newborn charges may be covered if the Plan Participant under this Plan is the father.

3. The Family Deductible Amount, as shown in the Schedule of Benefits, applies to all charges when a newborn is added to a Benefit Plan of a Plan Participant holding Employee Only coverage. This amount must be met prior to any Benefits being paid. In addition, coverage for the newborn will be pursuant to the provisions set forth in the Schedule of Eligibility Article of this Benefit Plan.

C. Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any hospital length of stay in connection with childbirth for the mother or Newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g., Physician, Midwife, or physician assistant), after consultation with the mother, discharges the mother or Newborn earlier.

Also, under federal law, Plans may not set the level of Benefits or Out-of-Pocket costs so that any later portion of the forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or Newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other healthcare Provider obtain Authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours. However, to use certain Providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Authorization. For information on Authorization, contact the Claims Administrator.

ARTICLE XIII. REHABILITATIVE CARE BENEFITS

Rehabilitative Care Benefits will be available for services and devices provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, Hearing Therapy, Cognitive Therapy, Cardiac Rehabilitation Pulmonary Rehabilitation and/or Chiropractic Services.

Benefits are available when services are rendered by a Provider licensed and practicing within the scope of his license. In order for care to be considered at an Inpatient rehabilitation facility, the Plan Participant must be able to tolerate a minimum of three (3) hours of active therapy per day.

An Inpatient rehabilitation Admission must be Authorized prior to the Admission and must begin within seventy-two (72) hours following the discharge from an Inpatient Hospital Admission for the same or similar condition, unless otherwise approved by the Claims Administrator.

Day Rehabilitation Programs for Rehabilitative Care may be Authorized in place of Inpatient stays for rehabilitation. Day Rehabilitation Programs must be Authorized prior to beginning the program and must

begin within seventy-two (72) hours following discharge from an Inpatient Admission for the same or similar condition.

Benefits for these services may be subject to any limitation or maximum Benefits if shown in the Schedule of Benefits.

Benefits under this Article are in addition to, but not a duplication of, the Benefits provided under any other provision of this Benefit Plan. Any Benefits provided under any other provision of this Benefit Plan will not be eligible Benefits under this Article.

A. **Occupational Therapy**

1. Occupational Therapy services are covered, as shown in the Schedule of Benefits, when performed by a Provider licensed and practicing within the scope of his license, including, but not limited to a licensed occupational therapist or a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist.

2. Occupational Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

3. Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.

B. **Physical Therapy**

1. Physical Therapy services are covered, as shown in the Schedule of Benefits, when performed by a licensed physical therapist practicing within the scope of his license.

2. Physical Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

3. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.

4. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances, if listed as a Covered Service:

   (a) To Children with a diagnosed developmental disability pursuant to the Plan Participant's plan of care.

   (b) As part of a home health care agency pursuant to the Plan Participant's plan of care.

   (c) To a patient in a nursing home pursuant to the Plan Participant's plan of care.

   (d) Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention in adults age sixty-five (65) years and older.

   (e) To an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate, after the physical therapist informs the healthcare Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The

physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered, when shown in the Schedule of Benefits, when performed by a Provider licensed to practice in the state in which the services are rendered and practicing within the scope of his license, including, but not limited to a speech pathologist or an audiologist. Speech Therapy is not covered when maintenance level of therapy is attained.

2. The therapy must be used to improve or restore speech language, cognitive-communication or swallowing function.

3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to receiving of services.

D. Hearing Therapy

Benefits are available under this Plan for hearing therapy**.**

E. Cognitive Therapy

Benefits are available under this Plan for cognitive therapy.

F. Pulmonary Therapy

Benefits are available for Pulmonary Rehabilitation Therapy services when rendered by a licensed therapy provider under the direction of a Physician.

G. Chiropractic Services

1. Chiropractic Services are covered, as shown in the Schedule of Benefits, when performed by a chiropractor licensed and practicing within the scope of his license.

2. Chiropractic Services are not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

3. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for the rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

ARTICLE XIV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

The following services are available to a Plan Participant, subject to other limitations shown in the Schedule of Benefits.

A. Acupuncture Benefits

Benefits are available for acupuncture when services are Medically Necessary. Benefits are limited to twelve (12) visits per Benefit Period. All other subsequent acupuncture visits are not covered.

B. Acute Detoxification

Benefits are available for the medical treatment of acute detoxification resulting from Substance Abuse.

C. Ambulance Service Benefits

1. Ground Ambulance Transport Services

   a. Emergency Transport

      Benefits for Ambulance Services are available for local transportation for Emergency Medical Conditions only as follows:

      (1) for Plan Participant, to the nearest Hospital capable of providing services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care;

      (2) for a Newly Born Infant, to the nearest Hospital or neonatal special care unit for treatment of illnesses, injuries, congenital birth defects and Complications of premature birth which require that level of care; or

      (3) for the Temporarily Medically Disabled Mother of an ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.

   b. Non-Emergency Transport

      Benefits for Ambulance Services are available for local transportation of Plan Participants for medical conditions that do not present an emergency to obtain medically necessary Inpatient or Outpatient services, when the Plan Participant is bed-confined, or his condition is such that the use of any other method of transportation is contraindicated. Benefits for non-Emergency transport are only available for transport to or from the nearest facility or Hospital capable of providing the Medically Necessary services.

      The Plan Participant must meet all of the following criteria for bed-confinement to qualify for non-Emergency transport:

      (1) unable to get up from bed without assistance; and

      (2) unable to ambulate; and

      (3) unable to sit in a chair or wheelchair.

   c. Transport by wheelchair van is not a covered Ambulance Service.

2. Air Ambulance Transport Services

   a. Emergency Transport

      Benefits for air Ambulance Services are available for Plan Participants with an Emergency Medical Condition. For Emergency Medical Conditions, the air Ambulance Service must be specifically requested by police or medical authorities present at the site with the Plan Participant in order for air Ambulance Services to be covered.

      Benefits for air Ambulance Services are available for or when the Plan Participant is in a location that cannot be reached by ground ambulance.

      The air Ambulance Transport is to the nearest facility or Hospital capable of providing services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care.

   b. Non-Emergency Transport

      Air Ambulance Service situations require prior Authorization from the Company. If Authorization is not obtained prior to services being rendered, the services will not be covered.

      If Authorized by the Company before services are rendered, Benefits for non-Emergency air Ambulance Services are available for Plan Participants, to the nearest facility or Hospital capable of providing services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care.

      Once Authorized, it is recommended that the Plan Participant verify the Network participation status of the Air Ambulance Provider in the state or area the point of pick up occurs, based on zip code.

      To locate a Participating Network Provider in the state or area where You will be receiving services, please call 1-800-810-2583 or go to the Blue National Doctor & Hospital Finder at **http://provider.bcbs.com**. Search for an Air Ambulance Provider by using the point of pick up zip code in the search criteria.

3. Ambulance Service Benefits will be provided as follows:

   a. If a Plan Participant pays a periodic fee to an ambulance membership organization with which the Company does not have a Provider agreement, Benefits for expenses incurred by the Plan Participant for its Ambulance Services will be based on any obligation the Plan Participant must pay that is not covered by the fee. If there is in effect a Provider agreement between the Company and the ambulance organization, Benefits will be based on the Allowable Charge.

   b. The medical transport services must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits.

   c. No Benefits are available if transportation is provided for a Plan Participant's comfort or convenience.

   d. No Benefits are available when a Hospital transports Plan Participant between parts of its own campus or when a hospital transports Plan Participant between facilities owned or affiliated with the same entity.

D. Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder is covered when rendered or prescribed by a Physician or Allied Health Professional.

E. Autism Spectrum Disorders (ASD)

ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Habilitative or Rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Plan Participants who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis, when the Company determines it is Medically Necessary. Applied Behavior Analysis is not covered for Plan Participants age twenty-one (21) and older.

ASD Benefits are subject to the Deductible Amount and Coinsurance that are applicable to the Benefits obtained. (Example: A Plan Participant obtains speech therapy for treatment of ASD. The Plan Participant will pay the applicable Deductible Amount or Coinsurance shown in the Schedule of Benefits for speech therapy).

F. Bone Mass Measurement

Benefits are available for scientifically proven Bone Mass Measurement tests for the diagnosis and treatment of osteoporosis if a Plan Participant is:

1. an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;

2. an individual receiving long-term steroid therapy; or

3. an individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.

Deductible and/or Coinsurance amounts are applicable.

G. BRCA1 and BRCA2 Genetic Testing

Genetic testing of BRCA1 and BRCA2 genes will be covered to detect an increased risk of breast and ovarian cancer when recommended by a healthcare provider in accordance with the United States Preventive Services Task Force recommendations for testing.

Genetic testing of BRCA1 and BRCA2 genes may be available to women at an increased risk, under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Preferred Provider.

H. Breast Reconstructive Surgery Services and Breast Cancer Long-Term Survivorship Care

1. Under the Women's Health and Cancer Rights Act, a Plan Participant who is receiving Benefits in connection with a mastectomy resulting from breast cancer and elects breast reconstruction will also receive Benefits for the following Covered Services:

    a. all stages of reconstruction of the breast on which the mastectomy has been performed;

    b. surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to contralateral prophylactic mastectomy, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical Complications which may require additional reconstruction in the future;

    c. prostheses; and

    d. treatment of physical Complications of all stages of the mastectomy, including lymphedema.

These Covered Services shall be delivered in a manner determined in consultation with the attending Physician and the Plan Participant and, if applicable, will be subject to any Copayment Amount, Deductible Amount, and Coinsurance percentage.

2. Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. Plan Participants eligible for screenings are those who:

   a. were previously diagnosed with breast cancer;

   b. completed treatment for breast cancer;

   c. underwent bilateral mastectomy; and

   d. were subsequently determined to be clear of cancer.

   These Covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with the attending Physician and the Plan Participant. Annual preventive cancer screenings under this Benefit will be subject to any Copayment Amount, Deductible Amount and Coinsurance percentage.

I. Cleft Lip and Cleft Palate Services

The following services for the treatment and correction of Cleft Lip and Cleft Palate are covered:

1. Oral and facial Surgery, surgical management, and follow-up care.

2. Prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

3. Orthodontic treatment and management.

4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

5. Speech-language evaluation and therapy.

6. Audiological assessments and amplification devices.

7. Otolaryngology treatment and management.

8. Psychological assessment and counseling.

9. Genetic assessment and counseling for patient and parents.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

J. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other Life-Threatening Illness or condition. Coverage will be subject to any applicable terms, conditions and limitations that apply under this Benefit Plan, including Deductible, or Coinsurance amounts shown in the Schedule of Benefits.

2. A “Qualified Individual” under this section means a Plan Participant that:

   a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Illness or condition;

b. And either,

(1) The referring healthcare professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the requirements in paragraph a, above; or

(2) The Plan Participant provides medical and scientific information establishing that the Plan Participant's participation in such trial would be appropriate based upon the Plan Participant meeting the conditions described in paragraph a, above.

3. An "Approved Clinical Trial" for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Illness or condition that:

a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(1) The National Institutes of Health.

(2) The Centers for Disease Control and Prevention.

(3) The Agency for Health Care Research and Quality.

(4) The Centers for Medicare & Medicaid Services.

(5) Cooperative group or center of any of the entities described in paragraphs (1) through (4) or the Department of Defense or the Department of Veterans Affairs.

(6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

b. The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.

c. The study or investigation is a drug trial that is exempt from having an Investigational new drug application.

d. The study or investigation is conducted by any of the below Departments, which study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

(1) The Department of Veterans Affairs.

(2) The Department of Defense.

(3) Department of Energy.

4. The following services are not covered:

a. Non-healthcare services provided as part of the clinical trial;

b. Costs for managing research data associated with the clinical trial;

c. Investigational drugs or devices, items or services themselves, and/or

d. Services, treatment or supplies not otherwise covered under this Benefit Plan.

5. Treatments and associated protocol-related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:

   a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other Life-Threatening Illness, or for the prevention or early detection of such diseases.

   b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial.

   c. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.

   d. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

   e. There must be no clearly superior, non-Investigational approach.

   f. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-Investigational alternative.

   g. The patient has signed an institutional review board approved consent form.

K. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

   a. Plan Participants that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, diabetic/nutritional counseling and for the equipment and necessary supplies for the training, if prescribed by the Plan Participant's treating Provider.

   b. Evaluation and training programs for diabetes self-management is covered subject to the following:

      (1) The program must be prescribed by the Plan Participant's treating provider and provided by a licensed healthcare professional who certifies that the Plan Participant has successfully completed the training program.

      (2) The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

   c. Benefits are not available for Diabetes Education and Training for Self-Management services rendered by a Non-Network Provider.

2. Diabetic Retinal Screening

   Diabetic Plan Participants are eligible to receive retinal eye screenings to detect and prevent diabetic retinopathy and other eye Complications, once per Benefit Period, at no cost to the Plan Participant when services are rendered by a Network Provider. Additional screenings or screenings by a Non-Network Provider are covered subject to contract benefits.

L. Disposable Medical Equipment or Supplies

Blue Cross and Blue Shield of Louisiana provides Claim payment services for Disposable Medical Equipment and Supplies provided by a medical Provider only when Medically Necessary and are subject to reasonable quantity limits as determined by the Claims Administrator.

M. Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered at the Coinsurance, as shown in the Schedule of Benefits.

1. Durable Medical Equipment

   a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be provided mainly for the comfort or convenience of the Plan Participant or others. In addition, the equipment must meet all of the following criteria:

      (1) it must withstand repeated use;

      (2) it is primarily and customarily used to serve a medical purpose;

      (3) it is generally not useful to a person in the absence of illness or injury; and

      (4) it is appropriate for use in the patient's home.

   b. Benefits for rental or purchase of Durable Medical Equipment.

      (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge);

      (2) At the Claims Administrator’s option, on behalf of the Plan Administrator, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, oxygen and oxygen equipment required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge;

      (3) Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Plan Participant selects deluxe equipment solely for his comfort or convenience;

      (4) Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary;

      (5) accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.

      (6) repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or replacement of equipment damaged due to neglect or misuse will not be covered. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Benefit Plan, will not be covered.

   c. Limitations in connection with Durable Medical Equipment.

      (1) there is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical

Equipment supplier;

(2) there is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose;

(3) there is no coverage for replacement of equipment lost. There is no coverage for repair or replacement of equipment damaged due to neglect or misuse;

(4) Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by the Claims Administrator. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by the Claims Administrator.

2. Orthotic Devices

Benefits as specified in this section will be available for the purchase of Orthotic Devices. These Benefits will be subject to the following:

a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.

b. Repair or replacement of the Orthotic Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. The Plan will determine this time period.

c. Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when a Plan Participant selects a deluxe device solely for his comfort or convenience.

d. Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented to be Medically Necessary.

e. No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease.

3. Prosthetic Appliances, Devices and Prosthetic Services of the Limbs (Non-Limb and Limb)

Benefits will be available for the purchase of Prosthetic Appliances, Devices and Prosthetic Services that the Claims Administrator Authorizes and are covered subject to the following:

a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.

b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Claims Administrator will determine this time period.

c. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.

d. Mastectomy bras, limited to 3 (three) per Plan Year.

e. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience. A Plan Participant may choose a Prosthetic Appliance or Device that is priced higher than the benefit payable under this Benefit Plan and may pay the difference between the price of the device and the benefit payable, without financial or contractual penalty to the provider of the device.

f. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

N. Eyeglasses

Benefits are available, as shown in the Schedule of Benefits, for eyeglass frames and lenses, or contact lenses when purchased within six (6) months following cataract surgery.

O. Gene Therapy and Cellular Immunotherapy Benefits

Gene Therapy and Cellular Immunotherapy are high cost, specialized treatments administered by a limited number of trained and quality Providers. Benefits are available for these services only: (1) WHEN WRITTEN AUTHORIZATION OF MEDICAL NECESSITY IS GIVEN BY COMPANY PRIOR TO SERVICES BEING PERFORMED; AND (2) SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM CLAIMS ADMINISTRATOR TO PERFORM YOUR PROCEDURE.

P. Hearing Benefits

1. Benefits are available for hearing aids for covered Plan Participants age seventeen (17) and under when obtained from a Network Provider. This Benefit is limited to one (1) hearing aid for each ear with hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the Child.

   The Plan will pay up to the Allowable Charge for this Benefit. The Plan may increase the Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge.

2. Eligible implantable bone conduction hearing aids are covered for all eligible Plan Participants, regardless of age, the same as any other service or supply, subject to the applicable Deductible Amount Coinsurance percentage.

Q. Home Health Care

1. Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered, and may be limited as shown in the Schedule of Benefits.

2. Home Health Care services provided to a Plan Participant must be ordered by a Physician and provided by or supervised by a registered nurse in the home setting.

3. Benefits are available when Home Health Care services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is defined as skilled nursing, skilled teaching and skilled rehabilitation services when:

   a. it is delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide safety of the patient;

   b it is ordered by a Physician;

   c. it requires clinical training in order to be delivered safely and effectively;

   d. it is not custodial.

R. Hospice Care

1. Hospice Care is covered when recommended by a Physician and may be limited if shown in the Schedule of Benefits.

2. Benefits are available for Hospice Care when provided by a licensed Hospice agency.

S. Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter/transliterator are covered at one-hundred percent (100%) of the allowable charge when the Plan Participant needs such services in connection with medical treatment or diagnostic consultations performed by a Physician or Allied Health Professional, if the services are required because of the Plan Participant's hearing loss or his failure to understand or otherwise communicate in spoken language. Services rendered by a family member are not covered.

T. Low Protein Food Products for Treatment of Inherited Metabolic Diseases

Low protein food products for treatment of certain Inherited Metabolic Diseases are covered. "Inherited Metabolic Disease" shall mean a disease caused by an inherited abnormality of body chemistry. "Low Protein Food Products" shall mean those foods that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low Protein Food Products shall not include natural foods that are naturally low in protein.

Benefits for Low Protein Food Products are limited to the treatment of the following diseases:

1. Phenylketonuria (PKU)

2. Maple Syrup Urine Disease (MSUD)

3. Methylmalonic Acidemia (MMA)

4. Isovaleric Acidemia (IVA)

5. Propionic Acidemia

6. Glutaric Acidemia

7. Urea Cycle Defects

8. Tyrosinemia

U. Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed Physician or received in a Hospital or other public or private facility authorized to provide lymphedema treatment. Coverage includes but is not limited to multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

V. Pain Management Programs

Benefits are available for Pain Rehabilitation Control and/or Therapy designed to develop an individual's ability to control or tolerate chronic pain.

W. **Permanent Sterilization Procedures and Contraceptive Devices**

Benefits are available for surgical procedures that result in permanent sterilization, including vasectomy.

Tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes are covered under

the Preventive or Wellness Care Benefit, at no cost to Plan Participants receiving care from a Network Provider.

Benefits are available for contraceptive intrauterine devices (IUDs), including the insertion and removal of such devices.

IUDs are covered under the Preventive or Wellness Care Article Benefit, at no cost to Plan Participants receiving care from a Network Provider.

X. Prescription Drugs

All Prescription Drugs approved for self-administration (e.g. oral and self-injectable drugs) must be obtained through the Prescription Drug Benefits Article of this Benefit Plan.

Y. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Only sleep studies performed as a home sleep study or sleep studies performed in a Network-accredited sleep laboratory are eligible for coverage. Plan Participants should check their provider directory or contact a customer service representative at the number listed on his ID card to verify that a sleep laboratory is accredited.

Z. Telehealth Services

Benefits are available to You for the diagnosis, consultation, treatment, education, care management, patient self-management, and caregiver support when You and your Provider are not physically located in the same place.

Interaction between Plan Participant and Provider may take place in different ways, depending on the circumstances. It must always be medically appropriate for the setting in which the services are provided.

Telehealth Services generally must be held in real time through an established patient portal by two-way video and audio transmissions simultaneously (Synchronous). Telehealth Services does not cover telephone calls, and only when approved by the Claims Administrator is it allowed by methods other than simultaneous audio and video transmission.

Store forward or Asynchronous Telehealth Services between an established Patient and their Provider relationship may take place when an established patient sends pre-recorded video or images to a Provider via HIPAA-compliant communication, at the Provider's request, or when the data is transferred between two Providers on the patient's behalf. This method of Telehealth Services is limited to services approved by the Claims Administrator.

The amount Plan Participants pay for a Telehealth Services visit may be different than the amount Plan Participants would pay for the same Provider's service in a non-Telehealth Services setting. Telehealth Services must be rendered by a Network Provider.

Blue Cross and Blue Shield of Louisiana has the right to determine if billing was appropriate and contains the required elements for the Claims Administrator to process the Claim.

In general, there is no coverage for Telehealth Services that are not within the scope of the Provider's License or fail to meet a standard of care compared to an in-person visit. Coverage does not exist for encounters supported by technology that is not HIPAA-compliant.

Telehealth Services and the Providers who can render those services are determined by the Claims Administrator.

AA. Urgent Care Center

An Urgent Care Center visit is covered as shown in the Schedule of Benefits.

BB. Vision Care

1. Non-routine Vision Care exams are subject to the Deductible and Coinsurance amounts, as shown on the Schedule of Benefits.

2. Benefits are available for eyeglass frames and one pair of eyeglass lenses or one pair of contact lenses required as a result of cataract surgery and purchased within six (6) months following the cataract surgery. Expenses incurred for the eyeglass frames will be limited to a maximum benefit of fifty dollars ($50.00).

ARTICLE XV. CARE MANAGEMENT

A. Authorization of Admissions, Services and Supplies, Selection of Provider, and Penalties

1. Selection of Provider

   A Plan Participant may generally obtain medical care from any Provider. Benefits will be paid at the highest Network level when care is received from a Network Provider.

   If a Plan Participant wants to receive services from a Non-Network Provider and obtain the highest level of Benefits, he must notify the Claims Administrator's Care Management Department before services are rendered. The Claims Administrator will approve the use of a Non-Network Provider only if the Claims Administrator determines that the services cannot be provided by a Network Provider within a seventy-five (75) mile radius of the Plan Participant's home.

   The Claims Administrator must approve the use of the Non-Network Provider and issue any required Authorization before services are rendered. If the Claims Administrator does not approve use of the Non-Network Provider and issue an Authorization prior to services being rendered, Covered Services that are later determined to be Medically Necessary will be paid at the lower Non-Network Level as shown on the Schedule of Benefits.

   An Authorization of Medical Necessity is not an approval of the use of a Non-Network Provider. These are two separate functions.

2. Penalties for Failure to Obtain Authorization – Admissions, Outpatient Services and Other Covered Services and Supplies

   If Authorization is not requested prior to Admission or receiving other covered services and supplies requiring an Authorization, the Plan will have the right to determine if the Admission or other covered services and supplies were Medically Necessary. If the services were not Medically Necessary, the Admission or other covered services and supplies will not be covered, and the Plan Participant must pay all charges incurred.

   If the services were Medically Necessary, Benefits will be provided based on the Network status of the Provider rendering the services, as follows.

   a. Admissions

      (1) If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.

      (2) If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with the other Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges.

          The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered.

          The Plan Participant remains responsible for any applicable Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

      (3) If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce the Coinsurance by the percentage shown in the Schedule of Benefits. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

b. Outpatient Services, Other Covered Services and Supplies

(1) If a Blue Cross Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.

(2) If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable unless the procedure is deemed medically necessary. If the procedure is deemed medically necessary, the Plan Participant remains responsible for his applicable Deductible and Coinsurance percentage. If the procedure is not deemed medically necessary, the Plan Participant is responsible for all charges incurred.

(3) If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce the Coinsurance by the percentage shown in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization. The Plan Participant is responsible for all charges not covered and remains responsible for his Deductible and applicable Coinsurance percentage.

3. Authorization of Admissions

a. Authorization of Elective Admissions

The Plan Participant is responsible for ensuring that his Provider notifies the Claims Administrator's Care Management Department of any Elective or non-emergency Inpatient Hospital Admission. The Claims Administrator must be notified (by calling the telephone number shown in the Schedule of Benefits or the Plan Participant's ID card) prior to the Admission regarding the nature and purpose of any Elective Admission or non-emergency Admission to a Hospital's Inpatient department. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Claims Administrator when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If a request for Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission is not covered and the Plan Participant must pay all charges incurred during the Admission for which Authorization was denied.

(2) If Authorization is not requested prior to an Admission, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the Network status of the Provider.

(3) Additional amounts for which the Plan Participant is responsible because Authorization of an Elective or non-emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

It is the Plan Participant's responsibility to ensure that his Physician or Hospital, or a representative thereof, notifies the Claims Administrator's Care Management Department of all Emergency Inpatient Hospital Admissions to guarantee coverage. Within forty-eight (48) hours of the Emergency Admission, the Claims Administrator must be notified (by calling the telephone number shown in the Schedule of Benefits or the Plan Participant's ID card) regarding the nature and purpose of the Emergency Admission. The Claims Administrator may waive or extend this time limitation if it determines that the Plan Participant is unable to timely notify or direct his representative to notify the Claims Administrator of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend the Claims Administrator must be notified on its next working day. The appropriate length of stay for the Emergency Admission will be determined by the Claims Administrator when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission will not be covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission for which Authorization was denied.

(2) If Authorization is not requested, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the Network status of the Provider.

(3) Additional amounts for which the Plan Participant is responsible because Authorization of an Emergency Admission was denied or not requested are considered non-covered and will not apply toward the Out-of-Pocket Amount.

c. Concurrent Review

When the Claims Administrator Authorizes a Plan Participant's Inpatient stay, the Claims Administrator will Authorize his stay in the Hospital for a certain number of days. If the Plan Participant has not been discharged on or before the last Authorized day, and the Plan Participant needs additional days to be Authorized, the Plan Participant must make sure his Physician or Hospital contacts the Claims Administrator's Care Management Department to request Concurrent Review for Authorization of additional days. This request for continued hospitalization must be made on or before the Plan Participant's last Authorized day so the Claims Administrator can review and respond to the request that day. If the Claims Administrator Authorized the request, the Claims Administrator will again Authorize a certain number of days, repeating this procedure until the Plan Participant is either discharged or the Plan Participant's continued stay request is denied.

(1) If the Claims Administrator does not receive a request for Authorization for continued stay on or before the Plan Participant's last Authorized day, no days are approved past the last Authorized day, and no additional Benefits will be paid unless the Claims Administrator receives and Authorizes another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and the Claims Administrator determines that it is not Medically Necessary for the Plan Participant to receive continued hospitalization or hospitalization at the level of care requested, the Claims Administrator will notify the Plan Participant and his Providers, in writing, that the request is denied and no additional days are Authorized.

(2) If the Claims Administrator denies a Concurrent Review request or level of care request for Hospital Services, the Claims Administrator will notify the Plan Participant, his Physician and the Hospital of the denial. If the Plan Participant elects to remain in the Hospital as an Inpatient thereafter, or at the same level of care, the Plan Participant will not be responsible for any charges unless he is notified of his financial responsibility by the Physician or Hospital in advance of incurring additional charges.

(3) Charges for non-authorized days in the Hospital that the Plan Participant must pay are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

4. Authorization of Outpatient Services, Including Other Covered Services and Supplies

Certain services, supplies, and Prescription Drugs require the Claims Administrator's Authorization before a Plan Participant receives the services, supplies, or Prescription Drugs. The Authorizations list is shown in the Plan Participant's Schedule of Benefits. The Plan Participant is responsible for making sure his Provider obtains all required Authorizations for him before he receives the services, supplies, or Prescription Drugs. The Claims Administrator may need the Plan Participant's Provider to submit medical or clinical information about the Plan Participant's condition. To obtain Authorizations, the Plan Participant's Provider should contact the Claims Administrator's Care Management Department at the telephone number shown on the Plan Participant's ID card.

a. If a request for Authorization is denied by the Claims Administrator, the Outpatient services and supplies are not covered.

b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, the Plan will have the right to determine if the services and supplies were Medically Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the Network status of the Provider.

c. Additional amounts for which the Plan Participant is responsible because Authorization of Outpatient services and supplies was denied or not requested are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

B. Population Health – In Health: Blue Health

1. Qualification

The Plan Participant may qualify for Population Health programs, at the Plan's discretion, based on various criteria, including a diagnosis of chronic illness, severity, and proposed or rendered treatment. The program seeks to identify candidates as early as possible. Self-management techniques are reinforced and a personal health coach is assigned. The Plan Participant, Physicians and caregivers may be included in all phases of the Population Health program. The Population health coach may also refer Plan Participants to community resources for further support and management.

2. Population Health Benefits

The Population Health program targets populations with one or more chronic health conditions. The current chronic health conditions identified by OGB are diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). OGB may supplement or amend the list of chronic health conditions covered under this program at any time.

Through the In Health: Blue Health Services program, the health coach works with Plan Participants to help them learn the self-care techniques they will need in order to manage their chronic disease, establish realistic goals for lifestyle modification, and improve adherence to their
Physician prescribed treatment plan. OGB and Blue Cross and Blue Shield of Louisiana are dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant.

The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.

The In Health: Blue Health Services program offers an incentive to Plan Participants on certain Prescription Drugs used to treat the chronic conditions listed above. The prescription incentive does not apply to any Prescription Drug not used to treat one of the health conditions with which You have been diagnosed.

To remain eligible for the Plan program, Plan Participants must actively engage with a BCBSLA health coach on a specified time interval appropriate for management of their healthcare needs. If Plan Participants fail to engage with the health coach on the determined timeframe, Plan Participants will not be eligible for a prescription incentive to treat chronic conditions listed above. Plan Participants can disenroll by calling 1-800-363-9159 and request disenrollment from the In Health: Blue Health Services program.

C. Case Management – In Health: Blue Touch

1. Case Management (CM) is the managed care available in cases of illness or injury where critical care is required and/or treatment of extended duration is anticipated. The Plan Participant may qualify for Case Management services at the Claims Administrator's discretion, based on various

criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.

2. Case Management may provide coverage for services that are not normally covered. To be eligible, the illness or injury must be a covered condition under the Plan, and Case Management must be approved prior to the rendering of services and/or treatment.

3. The role of Case Management is to service the Plan Participant by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.

4. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Case Management services will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant. The provision of Case Management services to one Plan Participant will not entitle any other Plan Participant to Case Management services or be construed as a waiver of the Claims Administrator's right, to administer and enforce this Plan in accordance with its express terms.

5. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Case Management services. Benefits for services and/or treatment approved by the Case Management are subject to the Deductible, Coinsurance and Allowable Charge.

6. The Plan Participant's Case Management services will be terminated upon any of the following occurrences:

   a. The Claims Administrator determines that the Plan Participant is no longer a suitable candidate for the Case Management services, or that the Case Management services are no longer necessary.

   b. The short and long-term goals established in the Case Management plan have been achieved, or the Plan Participant elects not to participate in the Case Management program.

7. Mental Health and Substance Use Disorder treatments/conditions are not eligible for Case Management.

8. The Claims Administrator must be the primary carrier at the time of enrollment in Case Management.

9. The Plan Participant may not be confined in any type of nursing home setting at the time of enrollment in Case Management.

D. Alternative Benefits

1. The Plan Participant may qualify for Alternative Benefits, at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. Case Management may provide coverage for services that are not normally covered. To be eligible, the illness or injury must be a covered condition under the Plan. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Plan Participant and to the Group.

2. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Alternative Benefits will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant; nor will the

provision of Alternative Benefits to a Plan Participant entitle any other Plan Participant to Alternative Benefits or be construed as a waiver of the Claims Administrator's right, to administer and enforce this Benefit Plan in accordance with its express terms.

3. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Alternative Benefits. Benefits for services and/or treatment approved by the Case Management are subject to the Deductible, Coinsurance and Allowable Charge.

4. Alternative Benefits provided under this Article are provided in lieu of the Benefits to which the Plan Participant is entitled under this Benefit Plan and apply toward the maximum Benefit limitations under this Benefit Plan.

5. The Plan Participant's Alternative Benefits will be terminated upon any of the following occurrences:

    a. The Claims Administrator determines, in their sole discretion, that the Plan Participant is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.

    b. The Plan Participant receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by the Claims Administrator.

ARTICLE XVI. LIMITATIONS AND EXCLUSIONS

Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary, as defined in this policy, are excluded by this Plan. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.

If a Plan Participant has Complications from excluded conditions, Surgery, or treatments, then Benefits for such conditions, services, Surgery, supplies and treatment are excluded.

Any of the limitations and exclusions listed in this Plan may be deleted or revised as shown in the Schedule of Benefits.

Unless otherwise shown as covered in the Schedule of Benefits, REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits for the following are excluded:

A. GENERAL

1. Medical services, supplies, treatments, and Prescription Drugs provided without charge to the Covered Person or for which the Covered Person is not legally obligated to pay.

2. Medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.

3. Diagnostic or treatment measures that are not recognized as generally accepted medical practice.

4. Services, Surgery, supplies, treatment, or expenses of a covered Plan Participant related to:

    a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or as required by law;

    b. Pre-implantation genetic diagnosis;

    c. Preconception carrier screening; and

    d. Prenatal carrier screening except screenings for cystic fibrosis.

5. Services and supplies for the treatment of and/or related to gender dysphoria.

6. Services rendered, prescribed, or otherwise provided by a Physician or other healthcare Provider who is the Plan Participant, related to the patient by blood, adoption or marriage or who resides at the same address.

7. Expenses for services rendered by a Physician or other healthcare Provider who is not licensed in the state where such services are rendered or in any facility not holding a valid license in the state and for the services rendered.

8. Facility fees for services rendered in a Physician’s office or in any facility not approved by the federal Health Care Finance Administration for Medicare reimbursement.

9. Charges to obtain medical records or any other information needed and/or required to adjudicate a claim.

10. Charges greater than the global allowance for any laboratory, pathology or radiological procedure.

11. Any charges exceeding the Allowable Charge.

12. Services, Surgery, supplies, treatment, or expenses:

a. other than those specifically listed as covered by this Benefit Plan or for which a Plan Participant has no obligation to pay, or for which no charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the State of Louisiana or any of its political subdivisions;

b. rendered or furnished before the Plan Participant's Effective Date or after Plan Participant's coverage terminates;

c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license;

d. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with the Claims Administrator's policies and procedures;

13. Anesthesia by hypnosis, or charges for anesthesia for non-covered services, except as specifically provided in this Benefit Plan.

14. Acupuncture when used to provide treatment for a condition or service that is excluded from coverage under this Benefit Plan.

15. Telephone calls, video communication, text messaging, e-mail messaging, or instant messaging or patient portal communications between the Plan Participant and their Provider unless specifically stated as covered under the Telehealth Services Benefit. Services billed with Telehealth Services codes not medically appropriate for the setting in which the services are provided. Telehealth Services rendered by Providers not Authorized by the Claims Administrator. Telehealth Services rendered by a Non-Network Provider is not covered.

16. Charges for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

17. Any incidental procedure, unbundled procedure or mutually exclusive procedure, except as described in this Benefit Plan.

18. No Benefits will be provided for the following, unless otherwise determined by this Plan:

    a. immunotherapy for recurrent abortion

    b. chemonucleolysis

    c. biliary lithotripsy

    d. home uterine activity monitoring

    e. sleep therapy

    f. light treatments for seasonal affective disorder (SAD)

    g. immunotherapy for food allergy

    h. prolotherapy

    i. hyperhidrosis surgery

    j. sensory integration therapy

19. Services provided at a free-standing or Hospital based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or

representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

a. has not been actively involved in the Plan Participant's medical care prior to ordering the service, or

b. is not actively involved in the Plan Participant's care after the service is received.

This exclusion does not apply to mammography testing.

20. Travel or transportation expenses, even though prescribed by a Physician.

21. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:

a. Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.

b. Related to judicial or administrative proceedings or orders.

c. Conducted for purposes of medical research.

d. Required to obtain or maintain a license of any type.

22. In the event that a Non-Network Provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.

23. Travel expenses of any kind or type other than covered Ambulance Services to the closest hospital equipped to adequately treat the Plan Participant's condition, except as specifically provided in this Benefit Plan, or as approved by the Claims Administrator.

24. Repatriation of remains from an international location back to the United States is not covered. Private or commercial air or sea transportation is not covered. Plan Participants traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to your home country and air/sea travel when ambulance is not required.

25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.

26. Any charge for services, supplies or equipment advertised by the provider as free.

27. Any charges prohibited by federal anti-kickback or self-referral statuses.

B. COSMETIC

1. Services, supplies, or treatment for cosmetic purposes, including cosmetic surgery and any cosmetic Complications of cosmetic surgery, unless necessary for the immediate repair of a deformity caused by disease and/or injury that occurs while coverage is in force. No payment will be made for expenses incurred in connection with the treatment of any body part not affected by the disease and/or injury.

2. REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits are excluded for services, Surgery, supplies, treatment or expenses for the following:

a. rhinoplasty;

b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;

c. hair pieces, wigs, hair growth and/or hair implants;

d. breast enlargement or reduction, except for Breast Reconstructive Surgical Services as specifically provided in this Benefit Plan;

e. implantation of breast implants and services; except for Breast Reconstruction Surgical Services specifically provided in this Benefit Plan;

f. implantation, removal and/or re-implantation of penile prosthesis and services; and

g. diastasis recti.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).

4. REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits are excluded for services, Surgery, supplies, treatment or expenses related to:

   a. weight reduction programs (other than for Plan Participants in programs approved by the Plan Administrator);

   b. bariatric surgery procedures including, but not limited to:

      (1) Roux-en-Y gastric bypass;

      (2) Laparoscopic adjustable gastric banding;

      (3) Sleeve gastrectomy; and

      (4) Duodenal switch with biliopancreatic diversion.

   c. removal of excess fat or skin or services at a health spa or similar facility; or

   d. obesity or morbid obesity regardless of Medical Necessity, except as required by law.

5. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings.

   This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.

6. Routine foot care; palliative or cosmetic care or treatment; and treatment of flat feet, except for Medically Necessary Surgery. Additionally, Benefits for cutting corns and calluses, nail trimming or debriding, or supportive devices of the foot are available for persons who have been diagnosed with diabetes.

7. Pharmacological regimens, nutritional procedures or treatments that are primarily for cosmetic purposes;

8. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other skin abrasion procedures); and skin abrasion procedures performed as a treatment for acne.

9. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.

10. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

11. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

12. Medical and surgical treatment of excessive sweating (hyperhidrosis).

13. Panniculectomy, abdominoplasty, thighplasty, brachioplasty and mastopexy.

C. COMFORT OR CONVENIENCE ITEMS

1. Maintenance therapy consisting of convalescent, skilled nursing, sanitarium, custodial care, assisted living facilities, or rest cures designed to assist in daily living activities, maintain present physical and/or mental condition, or provide a structured or safe environment.

2. Personal convenience items including, but not limited to, admit kits, bedside kits, telephone, television, guest meals, and beds, and charges for luxury accommodations in any hospital or allied health facility provided primarily for the patient's convenience which are not deemed Medically Necessary by the Claims Administrator.

3. Non-medical supplies such as air conditioners and/or filters, dehumidifiers, air purifiers, wigs or toupees, heating pads, cold devices, home enema equipment, rubber gloves, swimming pools, saunas, whirlpool baths, home pregnancy tests, lift chairs, devices or kits to stimulate the penis, exercise equipment, any other items not normally considered medical supplies.

4. Services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.).

5. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.

6. Medical and Surgical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).

7. Alternative Treatments including the following:

    a. Acupressure.

    b. Aromatherapy.

    c. Hypnotism.

    d. Massage therapy services when: services are not prescribed by a Physician; prior authorization is not obtained; or, services are not performed by a healthcare provider who is acting within the scope of his license.

    e. Rolfing.

    f. Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM).

8. Comfort or Convenience Items including the following:

    a. Television.

    b. Telephone.

    c. Beauty/Barber service.

    d. Guest service.

9. Services performed in the home unless the services meet the definition of Home Health, or otherwise covered specifically in this policy, or are approved by Us.

D. THIRD PARTY/PLAN PARTICIPANT RESPONSIBILITY OR FAULT

1. Injury compensable under any federal or state Workers Compensation Laws and/or any related programs, including but not limited to the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes regardless of whether or not coverage under such laws or programs is actually in force or whether the patient has filed a claim for benefits.

2. Services in the following categories:

   a. Those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;

   b. those occurring as a result of a Plan Participant's commission or attempted commission of a felony;

   c. for treatment of any Plan Participant detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention; or

   d. Health services for treatment of military service related disabilities, when the Plan Participant is legally entitled to other coverage and facilities are reasonably available.

E. DENTAL/VISION/HEARING

1. Dental and orthodontic services, appliances, supplies, and devices, including, but not limited to the following:

   a. Dental braces and orthodontic appliances, except as specifically provided in this Benefit Plan;

   b. Treatment of periodontal disease;

   c. Dentures, dental implants, and any surgery for their use, except if needed as the result of an accident that meets this Benefit Plan's requirements;

   d. Treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in this Benefit Plan;

   e. Expenses incurred for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, as specifically set forth herein, dental procedures which fall under the guidelines of treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral maxillofacial surgeries which are shown to the satisfaction of the Claim's Administrator to be Medically Necessary, non-dental, non-cosmetic procedures.

2. Diagnosis, treatment or Surgery of dentofacial anomalies including but not limited to, malocclusion, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition, except as specifically provided in this Benefit Plan.

3. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:

   a. Extraction, restoration and replacement of teeth

   b. Medical or surgical treatments of dental conditions

   c. Services to improve dental clinical outcomes

4. Dental implants.

5. Dental braces.

6. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:

    a. Transplant preparation

    b. Initiation of immunosuppressives

    c. The direct treatment of acute traumatic Injury, cancer or cleft palate

    d. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

7. Eye exercise therapy.

8. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

9. Routine vision examinations, including refractive examinations.

10. Routine eye examinations, glasses and contact lenses, except as specifically provided for in this Benefit Plan.

11. Services, Surgery, supplies, treatment or expenses related to:

    a. eyeglasses or contact lenses, unless shown as covered as provided in this Benefit Plan;

    b. eye exercises, visual training or orthoptics;

    c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;

    d. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser Surgery; or

    e. visual therapy.

F. DURABLE MEDICAL EQUIPMENT AND RELATED ITEMS

1. Correction or orthotic or inserts shoes and related items, such as wedges, cookies, and arch supports.

2. Glucometers.

3. Augmentative communication devices.

4. Any Durable Medical Equipment, items and supplies over reasonable quantity limits as determined by this Benefit Plan; all defibrillators other than implantable defibrillators authorized by the Claims Administrator.

5. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

6. Services or supplies for the prophylactic storage of cord blood.

7. Storage of tissue, organs, fluids or cells, with the exception of autologous bone marrow, the storage of which will be covered for a period not to exceed thirty (30) days.

8. Devices used specifically as safety items or to affect performance in sports-related activities.

9. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces.)

10. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

11. Oral appliances for snoring.

12. Medical supplies not specifically provided for in this Benefit Plan.

G. REPRODUCTIVE/FERTILITY

1. Maternity expenses incurred by any person other than the Employee or the Employee's Spouse.

2. Artificial organ implants, penile implants, transplantation of non-human organs, and any surgery and other treatment, services, or supplies, related to such procedures, or to Complications related to such procedures.

3. Expenses subsequent to the initial diagnosis for infertility and Complications, including but not limited to, services, drugs, procedures, or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, donor eggs, and reversal of sterilization procedures.

4. Elective medical or surgical abortion unless:

   a. the pregnancy would endanger the life of the mother; or

   b. the pregnancy is a result of rape or incest; or

   c. the fetus has been diagnosed with a lethal or otherwise significant abnormality.

5. Services, supplies or treatment related to artificial means of pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intra fallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.

6. Prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.

7. Paternity tests and tests performed for legal purposes.

H. HABILITATIVE

1. Services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, and dietary or educational instruction for all diseases and/or illnesses, except diabetes.

2. Counseling services, including but not limited to, marriage counseling, family relations counseling, divorce counseling, parental counseling, grief counseling, pastoral counseling, employment counseling and career counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.

3. Services of a licensed speech therapist when services are not prescribed by a Physician and prior authorization is not obtained.

4. Services of a licensed speech therapist when services are provided for any condition, except for the following: restoring partial or complete loss of speech resulting from stroke, surgery, cancer,

radiation laryngitis, cerebral palsy, accidental injuries, or other similar structural or neurological disease and Autism Spectrum Disorders.

5. Services, surgery, supplies, treatment or expenses for the following REGARDLESS OF CLAIM OF MEDICAL NECESSITY:

   a. biofeedback;

   b. lifestyle/habit changing clinics and/or programs except, those the law requires Us to cover or those the Plan Administrator offer, endorse, approve, or promote as part of Your healthcare coverage under this Benefit Plan. Some of these programs may be offered as value-added programs and may be subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the programs;

   c. Wilderness camp/programs except when provided by a qualified Residential Treatment Center and approved by Us as Medically Necessary for the treatment of mental health conditions or Substance Use Disorders;

   d. treatment related to sexual inadequacies, except for the Diagnosis and/or treatment of sexual dysfunction/impotence;

   e. treatment related to sex transformations;

   f. industrial testing or self-help programs (including, but not limited to supplies and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations, etc., except services required to be covered by law;

   g. recreational therapy; or

   h. services performed primarily to enhance athletic abilities;

6. Educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This includes Applied Behavior Analysis (ABA) services that are not habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or Custodial Care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law.

7. Sleep studies, unless performed as a home sleep study or performed in a in a Network-accredited sleep laboratory. If a sleep study is not performed by a Network-accredited sleep laboratory, as a home sleep study or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.

8. Applied Behavior Analysis (ABA) that the Claims Administrator has determined is not Medically Necessary. The following are also excluded: ABA rendered to Plan Participants age twenty-one (21) and older; ABA rendered by a Provider that has not been certified as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state and; Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

9. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

10. Tuition for or services that are school-based for Children and adolescents under the Individuals with Disabilities Education Act.

11. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

12. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

I. ORGAN TRANSPLANT

1. Services, Surgery, supplies, treatment or expenses related to:

   a. any costs of donating an organ or tissue for transplant when a Plan Participant is a donor except as provided in this Benefit Plan;

   b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high dose chemotherapy to support transplant procedures;

   c. the transplant of any non-human organ or tissue except as approved by the Claims Administrator (porcine valve);

   d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan; or

   e. Gene Therapy or Cellular Immunotherapy if prior Authorization is not obtained or if the services are performed at an administering Facility that has not been approved in writing by Company prior to services being rendered.

2. Health services for transplants involving mechanical or animal organs.

3. Transplant services that are not performed at a Network facility that is specifically approved by the Claims Administrator to perform organ transplants.

4. Any solid organ transplant that is performed as a treatment for cancer.

J. PRESCRIPTIONS/DRUGS

1. Vitamins, dietary supplements and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU) unless required by law.

2. Investigational drugs and drugs used other than for the FDA approved indication along with all Medically Necessary services associated with the administration of the drug, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals or the drug is expected to provide a similar clinical outcome for the covered indication as those included in nationally accepted standards of medical practice as determined by the Claims Administrator. These drugs may be covered by OGB's Pharmacy Benefit Administrator. Please refer to the Schedule of Benefits or call the Pharmacy Benefit Administrator at the telephone number on the back of the Plan Participant ID card.

3. Prescription Drugs for which coverage is available under the Prescription Drug Benefit, unless administered during an Inpatient or Outpatient stay or those that are medically necessary requiring parenteral administration in a Physician's office.

4. Prescription Drug products that contain marijuana, including medical marijuana.

K. MENTAL HEALTH/SUBSTANCE USE DISORDER

1. Methadone treatment as maintenance, L.A.A.M. (1-Alpha- Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.

2. Substance Use Disorder Services for the treatment of caffeine use.

3. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

4. Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.

5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Claims Administrator.

6. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or Substance Use Disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

    a. not consistent with generally accepted standards of medical practice for the treatment of such conditions;

    b. not consistent with services backed by credible research soundly demonstrating that the services or supplies will have measurable and beneficial health outcome, and therefore are considered experimental;

    c. typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective;

    d. not consistent with the level of care guidelines or best practices as modified from time to time, or

    e. not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.

7. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

8. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the Claims Administrator.

9. Services provided in a Residential Treatment Center for the active treatment of specific impairments of Mental Health or Substance Use Disorder, except as specifically provided in this Benefit Plan.

10. Treatment or services for mental health and Substance Use Disorder provided outside the treatment plan developed by the behavioral health provider. Services, supplies and treatment for services that are not covered under this Benefit Plan and Complications from services, supplies and treatment for services that are not covered under this Benefit Plan are excluded.

ARTICLE XVII. COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits ("COB") section applies to This Plan when a Member has healthcare coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. This Section is intended to describe whether the Benefits of This Plan are determined before or after those of another Plan when this Section applies.

The Benefits of This Plan:

a. will not be reduced when, under the terms of this Section and any applicable laws, This Plan determines its Benefits before another Plan.

b. may be reduced when under the terms of this Section or any applicable laws, another Plan determines its benefits first. That reduction is described in Subsection D of this Section, "When This Plan is Secondary."

B. Definitions (Applicable only to this Article of this Benefit Plan)

1. "Allowable Expense" means any healthcare expense, including coinsurance or copayments, and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

   a. If a Plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

   b. An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.

   c. Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

   d. The following are examples of expenses that are not Allowable Expenses.

      (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

      (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

      (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

      (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the Provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the secondary plan to determine its benefits.

2. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

3. "Claim" refers to a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

a. services (including supplies);

b. payment for all or a portion of the expenses incurred;

c. a combination of subsection a and b of this Subparagraph; or

d. an indemnification.

4. “Claim Determination Period or Plan Year” refers to a period of not less than 12 consecutive months over which Allowable Expenses shall be compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each Plan will pay or provide.

   a. The Claim Determination Period is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group or individual contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.

   b. As each claim is submitted, each Plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

5. “Closed Panel Plan” refers to a Plan that provides health benefits to covered persons primarily in the form of services through a pan el of Providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

6. “Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA” refers to coverage provided under a right of continuation pursuant to federal law.

7. “Coordination of Benefits or COB” refers to a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable Expenses.

8. “Custodial Parent”

   a. the parent awarded custody of a child by a court decree; or

   b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

9. “Group Insurance Contract” means an insurance policy or coverage that is sold in the group market and that are usually sponsored by a person’s employer, union, employer organization or employee organization.

10. “Group-Type Contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

11. “High-Deductible Health Plan” has the meaning given the term under section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

12. “Hospital Indemnity Benefits” are benefits not related to expenses incurred. Hospital indemnity benefits does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

13. “Individual Insurance Contract” means an insurance policy or coverage that is sold to an individual and/or his/her family in the individual market.

14. “Plan” means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its Benefit Plan shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the Benefit Plan uses the term “plan” or some other term such as “program,” the contractual definition may be no broader than the definition of “plan” in this Subsection.

    a. Plan includes:

        (1) Group Insurance Contracts, Individual Insurance Contracts and Subscriber contracts;

        (2) Uninsured arrangements of group or Group-Type coverage;

        (3) Group and non-group coverage through closed panel plans;

        (4) Group-Type Contracts;

        (5) The medical care components of long-term care contracts, such as skilled nursing care;

        (6) The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts;

        (7) Medicare or other governmental benefits, as permitted by law, except as provided in Subparagraph b of this definition. That part of the definition of “Plan” may be limited to the hospital, medical and surgical benefits of the governmental program; and

        (8) Group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

    b. Plan does not include:

        (1) Hospital indemnity coverage benefits or other fixed indemnity coverage;

        (2) Accident only coverage;

        (3) Specified disease or specified accident coverage;

        (4) Limited benefit health coverage as defined in La. R.S. 22:47(2)(c), except for group and non-group dental coverage;

        (5) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis;

        (6) Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

        (7) Medicare supplement policies;

(8) A state plan under Medicaid; or

(9) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

15. "Policyholder or Subscriber" means the primary insured named in an Individual Insurance Contract.

16. "Primary Plan" means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration.

    A Plan is a Primary Plan if:

    a. the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

    b. all plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

17. "Provider" means a healthcare professional or healthcare facility.

18. "Secondary Plan" means a Plan that is not a Primary Plan.

19. "This Plan" means the part of this Benefit Plan and any amendments/endorsements thereto that provides Benefits for healthcare expenses.

C. Order of Benefit Determination Rules

1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

    a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

        (1) Except as provided in Paragraph (2) below, a Plan that does not contain a coordination of benefits provision that is consistent with this Section is always primary unless the provisions of both Plans state that the complying plan is primary.

        (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

    b. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

    c. When a person is covered under a group Plan and a non-group (individual) Plan, the non-group Plan is always secondary to any group Plan, disregarding any other provision of this Section.

2. The following rules apply when group Plans coordinate benefits among themselves, and when non-group ("individual") Plans coordinate benefits among themselves. Each Plan determines its order of benefits **using the first of the following rules that applies, and discarding any other successive rules:**

    a. Non-Dependent or Dependent Rule. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, Subscriber or retiree is the

Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

b. Dependent Child Covered Under More Than One Plan Rule. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(a) The Plan of the parent whose Birthday falls earlier in the calendar year is the Primary plan; or

(b) If both parents have the same Birthday, the Plan that has covered the parent the longest is the Primary plan.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial parent;

(b) The Plan covering the Spouse of the Custodial parent;

(c) The Plan covering the non-custodial parent; and the

(d) The Plan covering the Spouse of the non-custodial parent.

(5) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provision s of Subparagraphs (2)(b)(1) or (2)(b)(2) above shall determine the order of benefits as if those individuals were the parents of the child.

(6) For a dependent child covered under the Spouse's plan:

(a) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a Spouse's plan, the rule in Subparagraph (2)(e) (Longer or Shorter Length in Coverage) applies.

(b) In the event the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule above in Subparagraph (2)(b)(1) to the dependent child's parent(s) and the dependent's Spouse.

c. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) can determine the order of benefits.

d. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) determine the order of benefits.

e. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an employee, member, policyholder, Subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

To determine the length of time a person has been covered under a Plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

The start of a new Plan does not include:

(1) a change in the amount or scope of a Plan's benefits;

(2) a change in the entity that pays, provides or administers the Plan's benefits; or

(3) a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

f. Fall-Back Rule. If none of the preceding rules determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, This Plan will never pay more than it would have paid had it been the Primary plan.

D. When this Plan is Secondary

Whenever This Plan is secondary to any other Plan, the Benefits of This Plan may be reduced so that no more than the Allowable Expense is ever paid for any given Claim taking into account all the benefits payable to the Member under all his/her Plans and sum of the Allowable Expenses for any Claim Determination Period. This will apply whether or not a Claim is made. The Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the Benefits of This Plan are reduced as described above, each Benefit is

reduced in proportion. It is then charged against any applicable Benefit limit of This Plan. In any event, This Plan will never pay more than it would have paid had it been the Primary plan.

E. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Us any facts We need to pay the Claim.

F. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. To the extent, such payments are made; they discharge Us from further liability. The term “payment made” includes providing benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments that this Plan made is more than it should have paid under this COB section, this Plan may recover the excess. It may get such recovery or payment from one or more of:

1. the persons it has paid or for whom it has paid;

2. insurance companies; or

3. other organizations.

The “amount of the payments made” includes the reasonable cash value of any Benefits provided in the form of services. If the excess amount is not received when requested, any Benefits due under this Plan will be reduced by the amount to be recovered until such amount has been satisfied.

ARTICLE XVIII. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP AND ALL PLAN PARTICIPANTS. THE GROUP IS THE PLAN ADMINISTRATOR FOR THIS BENEFIT PLAN.

BLUE CROSS AND BLUE SHIELD OF LOUISIANA PROVIDES ADMINISTRATIVE CLAIMS SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

A. This Benefit Plan

1. To the extent that this Benefit Plan may be an Employee welfare Benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the Plan Administrator of such Employee welfare Benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those that the Claims Administrator specifically undertake herein. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to Plan Participants for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or in the case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to

the Group. The Group will indemnify and hold the Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group's failure to do so.

2. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.

3. The (Plan Administrator) shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

4. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.

5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

6. Except as specifically provided herein, this Benefit Plan will not make the Claims Administrator liable or responsible for any duty or obligation that is imposed on the Employer by federal or state law or regulations.

7. The Plan Administrator will not discriminate on the basis of race, color, religion, national origin, disability, sex, age, protected veteran or disabled status or genetic information; and shall not impose eligibility rules or variations in premium based on a Plan Participant's health status or a health status-related factor.

B. Amending and Terminating the Benefit Plan

OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Employee, whether active or retired.

Any provision of the Plan which, on its effective date, is in conflict with applicable state law provisions (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

C. Employer Responsibility

1. It is the responsibility of the Participant Employer to submit enrollment and change forms and all other necessary documentation to the Plan Administrator on behalf of its Employees. Employees of a Participant Employer will not, by virtue of furnishing any documentation to the Plan Administrator, be considered agents of the Plan Administrator, and no representation made by any such person at any time will change the provisions of this Plan.

2. A Participant Employer shall immediately inform the Plan Administrator when a Retiree with OGB coverage returns to full-time or other benefit-eligible employment. The Retiree shall be placed in the Re-employed Retiree category for premium calculation. The Rehired Retiree premium classification

applies to Retirees with and without Medicare. The premium rates applicable to the Rehired Retiree premium classification shall be identical to the premium rates applicable to the classification for Retirees without Medicare.

3. A Participant Employer who receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the OGB MSP Adjuster within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a covered Employee. If not timely forwarded, OGB will assume responsibility only for Covered Plan benefits due to Medicare for a covered Employee. The Participant Employer will be responsible for interest, fines, and penalties due.

D. Identification Cards and Benefit Plans

The Claims Administrator will prepare an identification (ID) card for each covered Employee. The Claims Administrator will issue a Benefit Plan to the Group and print a sufficient number of copies of this Benefit Plan for the Group's covered Employees. At the direction of Group, the Claims Administrator will either deliver all materials to the Group for Group's distribution to the covered Employees, or the Claims Administrator will deliver the materials directly to each covered Employee.

Unless otherwise agreed between the Group and the Claims Administrator, the Group has the sole responsibility for distributing all such documents to covered Employees.

E. Benefits To Which Plan Participants are Entitled

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Benefit Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

F. Retroactive Cancellation of Coverage

1. The Plan Administrator may retroactively cancel coverage in the following instances:

   a. To the extent the cancellation of coverage is attributable to a failure of the Plan Participant to timely pay required premiums, contributions and surcharges toward the cost of coverage; or

   b. The cancellation of coverage is initiated by the Plan Participant.

2. When the Plan Administrator retroactively cancels coverage, the Plan Participant shall be liable to the Plan Administrator for all benefits paid on behalf of the Plan Participant after the effective date of rescission or cancellation of coverage.

G. Termination of a Plan Participant's Coverage Due to Fraud

The Plan may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment form. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed or covered Plan Participant, shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective date of coverage, or terminated within three (3) years of the Plan Participant's Effective Date, for fraud or intentional misrepresentation of material fact. The Plan will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If You enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

H. Reinstatement to Position Following Civil Service Appeal

1. Self-Insured Plan Participants

   When coverage of a terminated Employee, who was a participant in a self-insured health plan, is reinstated by reason of a civil service appeal, coverage will be reinstated to the same level in the Plan retroactive to the date coverage terminated. The Employee and Participant Employer are responsible for the payment of all premiums for the period of time from the date of termination to the date of the final order reinstating the Employee to his position. The Plan is responsible for the payment of all eligible benefits for charges incurred during this period. All claims for expenses incurred during this period must be filed with the Plan within 60 days following the date of the final order of reinstatement.

2. Fully Insured Health Maintenance Organization (HMO) Participants

   When coverage of a terminated Employee, who was a participant in a fully insured HMO, is reinstated by reason of a civil service appeal, coverage will be reinstated in the HMO in which the Employee was participating effective on the date of the final order of reinstatement. There will be no retroactive reinstatement of coverage and no premiums will be owed for the period during which coverage with the fully insured HMO was not effective.

I. Filing Claims

1. All Claims must be filed within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than twelve (12) months from the date services were rendered.

2. Most Plan Participants that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Plan Participant. However, if the Plan Participant must file a Claim to access his Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to the Claims Administrator, may require the signature of the dispensing pharmacist. The claim form should then be sent to the Claims Administrator's Pharmacy Benefit Manager, whose telephone number can be found on the Plan Participant's ID card.

J. Release of Information

The Claims Administrator may request that the Plan Participant or the Provider furnish certain information relating to the Plan Participant's Claim for Benefits.

The Claims Administrator will hold such information, records, or copies of records as confidential except where in the Claims Administrator's discretion the same should be disclosed.

K. Plan Participant/Provider Relationship

1. The selection of a Provider is solely the Plan Participant's responsibility.

2. The Claims Administrator and all network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. The Claims Administrator does not render Covered Services, but only makes payment, on behalf of the Plan, for Covered Services for which the Plan Participant receives. The Plan and the Claims Administrator will not be held liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any network Provider or in any network Provider's facilities. The Plan and the Claims Administrator have no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.

3. The use or non-use of an adjective such as Network and Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

L. Notice

Any notice required under this Plan must be in writing. Any notice required to be given to a Plan Participant will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Plan Participant at his address as the same appears on the Plan Administrator's records. Any notice that a Plan Participant is required to give to the Plan Administrator must be given at the Plan Administrator's address as it appears in this Benefit Plan. The Plan or a Plan Participant may, by written notice, indicate a new address for giving notice.

M. Job-Related Injury or Illness

The Group must report to the appropriate federal or state governmental agency any job-related injury or illness of a Plan Participant where so required under the provisions of any federal or state laws and/or related programs. This Plan, with any described exceptions, excludes Benefits for any services rendered as a result of occupational disease or injury compensable under any federal or state Workers Compensation laws and/or any related programs including, but not limited to the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes whether or not coverage under such laws or programs is actually in force. In the event Benefits are initially extended by the Plan and a compensation carrier, or employer, governmental agency or program, insurer, or any other entity makes any type of settlement with the Plan Participant, or with any person entitled to receive settlement where the Plan Participant dies, or if the Plan Participant's injury or illness is found to be compensable under federal or state Workers Compensation laws or programs, the Plan Participant must reimburse the Plan for Benefits extended or direct the compensation carrier, employer, governmental agency or program, insurer, or any other entity to make such reimbursement. The Group will be entitled to such reimbursement even if the settlement does not mention or excludes payment for healthcare expenses.

N. Subrogation and Reimbursement

Upon payment of any eligible Benefits covered under this Plan, the Office of Group Benefits plan shall succeed and be subrogated to all rights of recovery of the Plan Participant or his/her heirs or assigns for whose benefit payment is made and the Plan Participant shall execute and deliver instruments and papers and do whatever is necessary to secure such rights and shall do nothing to prejudice such rights. The Office of Group Benefits shall have an automatic lien against and shall be entitled, to the extent of any payment made to a Plan Participant and/or his/her heirs or assigns, to 100% of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a Plan Participant and/or his/her heirs or assigns against any person or entity legally responsible for the disease, illness, accident, or injury for which said payment was made.

To this end, Plan Participants agree to immediately notify the Office of Group Benefits or its agent assigned to exercise reimbursement and subrogation rights on its behalf of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident, or injury. These subrogation and reimbursement rights also apply, BUT ARE NOT LIMITED TO, when a Plan Participant recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

Under these subrogation and reimbursement rights, the Office of Group Benefits has a right of first recovery to the extent of any judgment, settlement, or any payment made to the Plan Participant and/or his/her heirs or assigns. These rights apply whether such recovery is designated as payment for pain and suffering, medical benefits, or other specified damages, even if the Plan Participant is not made whole (i.e., fully compensated for his/her injuries).

O. Right of Recovery

Whenever any payment for Covered Services has been made by the Plan, in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or exceeds the Allowable Charge, or whenever payment has been made in error by the Plan for non-covered services, the Plan will have the right to recover such payment from the Plan Participant or, if applicable, the Provider.

As an alternative, the Plan reserves the right to deduct, from any pending Claim for payment under this Benefit Plan, any amounts the Plan Participant or Provider owes the Plan.

P. Coverage in a Department of Veterans Affairs or Military Hospital

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from the Plan to the extent the veteran would be eligible for Benefits for such care or services from the Plan if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

The United States will have the right to collect from the Plan the reasonable cost of healthcare services incurred by the United States on behalf of a military Retiree or a military Dependent through a facility of the United States military to the extent that the Retiree or Dependent would be eligible to receive reimbursement or indemnification from the Plan if the Retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

Q. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan of Benefits constitutes a contract solely between the Plan Administrator and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Blue Cross and Blue Shield of Louisiana and its subsidiaries and affiliates (collectively “Blue Cross and Blue Shield of Louisiana”), to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Plan Administrator, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Plan Administrator for any of Blue Cross and Blue Shield of Louisiana's obligations to the Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of the claims administration agreement.

R. Out-of-Area Services

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”). Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever You obtain healthcare services outside the geographic area Blue Cross and Blue Shield of Louisiana serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of Blue Cross and Blue Shield of Louisiana’s service area, You will receive it from one of two kinds of Providers. Most Providers (“Participating Providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some Providers (“Non-Participating Providers”) don’t contract with the Host Blue. The Claims Administrator explains

below how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits when paid as medical Benefits, and those Prescription Drug Benefits or vision care Benefits that may be administered by a third party contracted by the Claims Administrator to provide the specific service or services.

1. BlueCard® Program

   Under the BlueCard® Program, when Plan Participants access covered healthcare services within the geographic area served by a Host Blue, Claims Administrator will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Network Providers.

   When You receive Covered Services outside Blue Cross and Blue Shield of Louisiana's service area and the Claim is processed through the BlueCard® Program, the amount You pay for the Covered Services is calculated based on the lower of:

   - the billed covered charges for Your Covered Services; or
   - the negotiated price that the Host Blue makes available to The Plan.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for Your Claim because they will not be applied after a Claim has already been paid.

2. Special Case: Value-Based Programs

   a. BlueCard® Program

      If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

   b. Negotiated (non-BlueCard® Program) Arrangements

      If the Claims Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on Your behalf, the Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

   Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the Claim charge passed on to You.

4. Non-Participating Providers Outside Blue Cross and Blue Shield of Louisiana's Service Area

   a. Plan Participant Liability Calculation

      When Covered Services are provided outside of Blue Cross and Blue Shield of Louisiana's service area by Non-Participating Providers, the amount You pay for such services will normally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, may govern payments for out-of-network Emergency Medical Services.

   b. Exceptions

      In certain situations, the Claims Administrator may use other payment methods, such as billed charges for Covered Services, the payment the Claims Administrator would make if the healthcare services had been obtained within Blue Cross and Blue Shield of Louisiana's service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

5. Blue Cross Blue Shield Global® Core

   If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard® service area"), You may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists You with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard® service area, You will typically have to pay the Providers and submit the Claims Yourself to obtain reimbursement for these services.

   If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

   a. Inpatient Services

      In most cases, if You contact the Blue Cross Blue Shield Global® Core service center for assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if You paid in full at the time of service, You must submit a Claim to receive reimbursement for Covered Services. You must contact the Claims Administrator to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

   b. Outpatient Services

      Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area will typically require You to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

c. Submitting a Blue Cross Blue Shield Global® Core Claim

When You pay for Covered Services outside the BlueCard® service area, You must submit a Claim to obtain reimbursement. For institutional and professional Claims, You should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of Your Claim. The claim form is available from Blue Cross and Blue Shield of Louisiana, the Blue Cross Blue Shield Global® Core service center, or online at **www.bcbsglobalcore.com**. If You need assistance with Your Claim submission, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

S. Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage

The Plan Administrator shall provide to certain Plan Participants who have Prescription Drug coverage under this Plan, without charge, a written certification that their Prescription Drug coverage under this Plan is either creditable or non-creditable. Coverage is deemed creditable if it is at least as good as the standard Medicare Part D Prescription Drug benefit. The Plan Administrator will provide these Certificates to Plan Participants who are eligible for Medicare Part D based upon enrollment data.
The Plan Administrator will provide Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to covered Plan Participants at the following times, or as designated by law:

1. prior to the Medicare Part D Annual Coordinated Election Period;

2. prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D;

3. whenever Prescription Drug coverage under this Benefit Plan ends;

4. whenever Prescription Drug coverage under this Plan changes so that it is no longer creditable or becomes creditable; and/or

5. upon a Medicare beneficiary's request.

T. Compliance with HIPAA Privacy Standards

The Plan Administrator's workforce performs services in connection with administration of the Plan. In order to perform these services, it is necessary for these workforce members, from time to time, to have access to Protected Health Information (as defined below).

Under the Standards of Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these workforce members are permitted to have such access subject to the following:

1. General

The Plan shall not disclose Protected Health Information to any member of the Plan Administrator's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or Mental Health condition of a Plan Participant, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

Protected Health Information disclosed to members of the Plan Participant's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative

functions shall include all Plan payment and healthcare operations. The terms “payment” and “healthcare operations” shall have the same definitions as set out in the Privacy

Standards, the term “payment” generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of Benefits or reimbursement for healthcare. “Healthcare Operations” generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of healthcare providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

3. Authorized Workforce Members

The Plan shall disclose Protected Health Information only to members of the Plan Administrator’s workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan.

For purposes of this HIPAA Privacy section, “members of the Plan Administrator’s workforce” shall refer to all workforce members and other persons under the control of the Plan Administrator. State of Louisiana, Office of Group Benefits staff, contractors, and designees are authorized to receive Protected Health Information in order to perform their respective duties.

a. Updates Required. The Plan Administrator shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

b. Use and Disclosure Restricted. An authorized workforce member of the Plan Administrator’s workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

c. Resolution of Issues of Noncompliance. In the event that any member of the Plan Administrator’s workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

(1) investigating the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach may include oral or written reprimand, additional training or termination of employment;

(3) mitigating any harm caused by the breach, to the extent practicable; and

(4) documenting the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Participant Employer/Plan Sponsor

The Participant Employer agrees to:

a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Participant Employer and Plan Administrator with respect to such information;

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Participant Employer;

d. report any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. if feasible, return or destroy all Protected Health Information in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. ensure the adequate separation between the Plan and the Participant Employer, as required by Section 164.504 (f) (2) (iii) of the Privacy Standards.

U. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan Administrator agrees to the following:

1. The Plan Administrator agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Plan Administrator creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Plan Administrator shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Plan Administrator shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections (3) Authorized workforce members and (4) Certification of Plan Administrator described above in this Article.

ARTICLE XIX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

OGB Eligibility Appeal Process

OGB retains the authority to make all determinations regarding eligibility, except for rescissions of coverage determinations and those determinations involving medical judgment regarding the incapacity of over-age Dependents. All eligibility Appeals other than for rescissions of coverage determinations and those determinations involving medical judgment regarding the incapacity of over-age Dependents must be submitted within 180 calendar days following the denial of coverage to State of Louisiana Office of Group Benefits, Post Office Box 44036, Baton Rouge, Louisiana 70804 (rather than Blue Cross and Blue Shield of Louisiana), and OGB shall have sixty (60), rather than thirty (30), calendar days in which to respond to the Appeal. Rescissions of coverage determinations and those determinations regarding the incapacity of over-age Dependents shall be subject to the procedures set forth in Section C below.

Pharmacy Benefit Manager Appeals Process

Pharmacy Benefit Manager appeals information is available by calling MedImpact's Customer Contact Center at 800.788.2949 or by going to **www.groupbenefits.org**. Upon your written request, OGB will provide you a copy of the Pharmacy Benefit Manager appeals information at no charge.

A. COMPLAINTS AND GRIEVANCES: Quality of Care or Services

The Claims Administrator wants to know when a Plan Participant is dissatisfied with the quality of care or services received from the Claims Administrator or a Network Provider. If a Plan Participant or his Authorized representative wants to register an oral Complaint or file a formal written Grievance about the quality of care or services received from the Claims Administrator or a Network Provider, he should refer to the procedures below.

1. Complaints

A Complaint is an **oral** expression of dissatisfaction with Us or with Provider services. A quality of service concern addresses appropriateness of care given to a Plan Participant, Our services, access, availability or attitude and those of Our Network Providers.

To make a Complaint, call the Claims Administrator's customer service department at 1-800-392-4089. The Claims Administrator will attempt to resolve the Complaint at the time of the call.

If a Plan Participant or his Authorized Representative is dissatisfied with the Claims Administrator's resolution, he may file a first level Grievance.

2. Grievances

A Grievance is a **written** expression of dissatisfaction with the quality of care or services received from the Claims Administrator or a Network Provider. **To file a first level Grievance**, send the first level Grievance to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

The Claims Administrator's customer service department will assist the Plan Participant or his Authorized Representative with filing the first level Grievance, if necessary.

The Claims Administrator will mail a response to the Plan Participant or his Authorized Representative within thirty (30) calendar days from the date the Claims Administrator receives the first level Grievance.

B. INFORMAL RECONSIDERATION: Pre-Service Denial Based on Medical Necessity or Investigational Determinations

In addition to the Appeal rights, the Plan Participant's Provider may initiate an Informal Reconsideration to review Utilization Management decisions.

Informal Reconsideration

An Informal Reconsideration is a process to review Utilization Management decisions and is initiated by a request by telephone, made by an authorized Provider to speak to the Claims Administrator's Medical Director or to a peer reviewer. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

An Informal Reconsideration is available only if requested within **ten (10) calendar days** of the date of the initial denial or adverse Concurrent Review determination. The Claims Administrator will conduct the Informal Reconsideration within **one (1) business day** from the receipt of the request. Once the Informal Reconsideration is complete, the Claims Administrator will advise the Plan Participant or his Authorized Representative of the decision and, if necessary, the Plan Participant's additional Appeal rights.

C. APPEALS: Standard Appeal, External and Expedited Appeals

A Plan Participant may be dissatisfied with coverage decisions made by the Claims Administrator. For example, rescissions of coverage, denied Authorizations, Investigational determinations, adverse Medical Necessity determinations, Adverse Benefit Determinations based on medical judgment, denied Benefits (in whole or in part), or adverse Utilization Management decisions.

A Plan Participant's Appeal rights, including a right to an Expedited Appeal, are outlined below.

Standard Appeals Process

An Appeal is a **written** expression of dissatisfaction with coverage decisions made by the Claims Administrator. A Plan Participant or his Authorized Representative may file an administrative Appeal or a medical Appeal. The Plan Participant or his Authorized Representative is encouraged to submit written comments, documents, records, and other information relating to adverse coverage decisions.

If the Plan Participant or his Authorized Representative has questions or needs assistance putting an Appeal in writing, or wishes to communicate with the Claims Administrator regarding an Appeal, he may call the Claims Administrator's customer service department at 1-800-392-4089.

MULTIPLE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED, AT ANY LEVEL OF REVIEW.

The Appeal process has two (2) mandatory levels of review. At each level of review, the review will involve persons who did not participate in any prior Adverse Benefit Determination and who are not a subordinate to any previous adverse decision-maker. When the Appeal requires medical judgment, the review will involve a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Administrative Appeals

Administrative Appeals involve contractual issues, Rescissions of Coverage, and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or Investigational.

1. First Level Administrative Appeal

If the Plan Participant is not satisfied with the Claims Administrator's decision, a written request must be submitted within **one hundred eighty (180) calendar days** of receipt of the initial Adverse

Benefit Determination for first level administrative Appeals. Request submitted to the Claims Administrator after one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. If the administrative Appeal is denied, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The administrative Appeal decision will be mailed to the Plan Participant, the authorized representative, or Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request: unless the Claims Administrator and Plan Participant mutually agreed that an extension of the time is warranted.

All administrative Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

2. Second Level Administrative Appeal

After review of the Claims Administrator's first level Appeal decision, if the Plan Participant is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of receipt of the first level Appeal decision. Requests submitted after sixty (60) calendar days of receipt of the first level Appeal decision will not be considered.

An Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level Appeals. The Committee's decision is considered final and binding.

The Committee's decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within five (5) days of the Committee meeting.

Send a written request for further review and any additional information to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

3. OGB Voluntary Level Appeal

Not applicable to a rescission of coverage Appeal or any Appeal requiring medical judgment. These Appeals follow the second level external review track for medical Appeals.

The Plan Participant or his Authorized Representative has **thirty (30) calendar days** from receipt of the notice denying the second level administrative Appeal to file an OGB voluntary level Appeal. **To file an OGB voluntary level Appeal,** send the OGB voluntary level Appeal to:

Office of Group Benefits
Administrative Claims Committee
P. O. Box 44036
Baton Rouge, LA 70804

along with copies of all information relevant to the Appeal. The Plan Participant or his Authorized Representative is entitled to receive free of charge, copies of all information relevant to the Appeal

from the Claims Administrator (Blue Cross and Blue Shield of Louisiana, Claims Administrator, Appeals and Grievance Unit, P. 0. Box 98045, Baton Rouge, LA 70898-9045).

If the Administrative Claims Committee (ACC) grants the OGB voluntary level Appeal, the Plan Participant will be notified and the Claims Administrator will reprocess the claim. If the ACC denies the OGB voluntary level Appeal, the ACC will notify the Plan Participant or his Authorized Representative, in writing, of the decision within sixty (60) calendar days from the date the ACC received the OGB voluntary level Appeal, or as allowed by law.

Medical Appeals

Medical Appeals involve Adverse Benefit Determinations for Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational and any related prospective or retrospective review determination.

Medical Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana
Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022

1. First Level Internal Medical Appeals

If the Plan Participant is not satisfied with the Claims Administrator's decision, a written request to Appeal must be submitted within **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination for internal medical Appeals. Requests submitted to the Claims Administrator after **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination will not be considered.

A Physician or other healthcare professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, the Claims Administrator will reprocess the Plan Participant's Claim, if any. If the internal medical Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The internal medical Appeal decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request; unless the Claims Administrator and Plan Participant mutually agreed that an extension of the time is warranted.

If the first level Appeal is denied or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative may request a Second Level Appeal (External Review).

2. Second Level Medical / External Appeals

If the Plan Participant still disagrees with the determination on his Claim, or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative must send their written request for an external Appeal, conducted by a non-affiliated Independent Review Organization (IRO), within **one hundred twenty (120) calendar days** of receipt of the internal Appeal decision, to:

Blue Cross and Blue Shield of Louisiana
Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022

Requests submitted to the Claims Administrator after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered. The Plan Participant is required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. **Appeals submitted by your Provider will not be accepted without this form completed with Your signature.**

The Claims Administrator will conduct a preliminary review to determine whether the Plan Participant has a right to an external review within five (5) business days of receiving the request. The Claims Administrator will notify the Plan Participant or his Authorized Representative, in writing, of the decision and requirements for any further action by the Plan Participant or his Authorized Representative within one (1) business day after completing the preliminary review.

If an external review right exists, the Claims Administrator will provide the IRO all pertinent information necessary to conduct the external Appeal. The external review will be completed within forty-five (45) days of receipt of the external Appeal request. The IRO will notify the Plan Participant or their authorized representative and all appropriate Providers of its decision.

The IRO decision is considered final and binding.

If you need help or have questions about Your Appeal rights, call the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA or 1-866-444-3272.

Expedited Appeals Process

The expedited Appeal process is available for review of the Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize the Plan Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the Plan Participant's treating Physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Expedited Appeals are not provided for review of services previously rendered.

An Expedited Appeal shall be made available to, and may be initiated by the Plan Participant, his authorized representative, or a Provider authorized to act on the Plan Participant's behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

1. Expedited Internal Medical Appeals

   In these cases, We will make a decision no later than seventy-two (72) hours of our receipt of an Expedited Appeal request that meets the criteria for Expedited Internal medical Appeal.

   In any case where the internal Expedited Internal medical Appeals process does not resolve a difference of opinion between the Claims Administrator and the Plan Participant or the Provider acting on behalf of the Plan Participant, the Appeal may be elevated to an Expedited External medical Appeal.

   If an Expedited internal medical Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process and timeframe.

2. Expedited External Medical Appeal

   An Expedited External medical Appeal is a request for immediate review, by an Independent Review Organization (IRO). The request may be simultaneously filed with a request for an internal Expedited medical Appeal, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for Expedited External medical Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

D. Exhaustion

The Plan Participant will have exhausted his administrative remedies under the Plan when the Plan Participant completes any one of the following steps:

- The OGB Eligibility Appeal process;
- Pharmacy Benefit Manager Appeal process;
- The Second Level Expedited Appeal process;
- The Second Level Internal Appeal process;
- The OGB Voluntary Level Appeal process; or,
- The External Review process.

After exhaustion, a claimant may pursue any other legal remedies available to him.

E. Legal Limitations

A Plan Participant must exhaust his administrative remedies before filing a legal action. A lawsuit related to a claim must be filed no later than twelve (12) months after the claim is required to be filed, or more than thirty (30) calendar days after the Plan Participant has exhausted his administrative remedies, whichever is later.

Any and all lawsuits, other than those related to claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

ARTICLE XX. OBTAINING CARE WHILE TRAVELING, MAKING PLAN CHANGES AND FILING CLAIMS

The Claims Administrator is continuing to update its online access for Plan Participants. Plan Participants may now be able to perform many of the functions described below, without contacting the Claims Administrator's customer service department. The Claims Administrator invites Plan Participants to log on to **www.bcbsla.com** for access to these services.

All of the forms mentioned in this section can be obtained from the Claims Administrator's regional offices. If the Plan Participant needs to submit documentation to the Claims Administrator, the Plan Participant may forward it to Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA 70898-9029, or to 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Plan Participant has any questions about any of the information in this section, the Plan Participant may call the Claims Administrator's customer service department at the telephone number shown on his ID card.

A. How to Obtain Care While Traveling

The Plan Participant's ID card offers convenient access to PPO healthcare outside of Louisiana. If the Plan Participant is traveling or residing outside of Louisiana and needs medical attention, please follow these steps:

1. In an Emergency, go directly to the nearest Hospital.

2. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest PPO Network Providers.

3. Use a designated PPO Network Provider to receive the highest level of Benefits.

4. Present the Plan Participant's ID card to the Provider, who will verify coverage and file Claims for the Plan Participant.

5. The Plan Participant must obtain any required Authorizations from the Claims Administrator.

B. How to File Claims for Benefits

The Claims Administrator and most Providers have entered into agreements that eliminate the need for a Plan Participant to personally file a Claim for Benefits. Network Providers will file Claims for Plan Participants either by mail or electronically. In certain situations, the Provider may request the Plan Participant to file the Claim. If the Plan Participant's Provider does request the Plan Participant to file directly with the Claims Administrator, the following information will help the Plan Participant in correctly completing the claim form.

The Plan Participant's Blue Cross and Blue Shield of Louisiana ID card shows the name of the Employee as it appears on the Claims Administrator's records. The ID card also lists the Plan Participant's ID number. This number is the identification to the Plan Participant's membership records and should be provided to the Claims Administrator each time a Claim is filed. To assist in promptly handling the Plan Participant's Claims, the Plan Participant must be sure that the appropriate Claim form is used, and includes following:

1. Full name of the patient

2. Plan Participant ID number, as shown on the ID card

3. Patient's date of birth

4. Patient's relationship to the Employee

5. All services are itemized, with the appropriate diagnosis and procedure codes and descriptions, for each service/treatment rendered, along with the charge for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)

6. Date(s) of service /date(s) of treatment is correct

7. Name and address of Provider of service/treatment

8. Signed by the Plan Participant and the Provider.

   IMPORTANT NOTE: The Plan Participant must be sure to check all Claims for accuracy. The Member ID number must be correct. It is important that the Plan Participant keep a copy of all bills and Claims submitted.

C. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

   When a Plan Participant is being admitted to a Network Provider, Hospital or Allied Health Facility, the Plan Participant should show his Blue Cross and Blue Shield ID card to the admitting clerk. The Provider will file the claim with the Claims Administrator. The Plan's payments will go directly to the Network Provider. The Provider will then bill the Plan Participant directly for any remaining balance. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

2. Outpatient Department Claims

   The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility. However, in some instances involving Outpatient treatment, the Non-Network Provider may ask for payment directly from the Plan Participant. If this occurs, the Plan Participant should obtain an itemized copy of the bill, be sure the claim form correctly notes the Plan Participant ID number, the patient's date of birth, as well as the patient's relationship to the Employee. The Provider must mark the bill or claim form PAID. This statement should then be sent to the Claims Administrator.

3. Emergency Room Claims

   When a Plan Participant has Emergency Room services performed by a Network or Non-Network Provider, the Plan Participant should show his ID card to the admitting clerk. The Provider will file the Claim with Us. Benefit payment will be sent directly to the Provider. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

4. Prescription Drug Claims

   Most Plan Participants with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Plan Participants who present an ID card to a Participating Pharmacist. However, if the Plan Participant must file a Claim to access his Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. Plan Participants may obtain the Prescription Drug Claim form by accessing the pharmacy section of Our website, **www.bcbsla.com/pharmacy**.The Prescription Drug Claim Form, or an attachment acceptable to the Claims Administrator, may require the signature of the dispensing pharmacist.

   The claim form should then be sent to the Claims Administrator or their Pharmacy Benefit Manager, whose telephone number can be found on the Plan Participant's ID card. Benefits will be paid to the Plan Participant based on the Allowable Charge for the Prescription Drug.

5. Durable Medical Equipment (DME) Claims

   Charges for rental or purchase of wheelchairs, braces, crutches, etc. must be on the bill of the supplying firm, giving a description of the item rented or purchased, the date, the charge, and the patient's name.

A statement from the attending Physician or Allied Health Provider that services were Medically Necessary must also be filed with these bills.

6. Mental Health and/or Substance Use Disorder Claims

   For help with filing a Claim for Mental Health and/or Substance Use Disorders, the Plan Participant should refer to his ID card or call the Claims Administrator's customer service department.

7. Other Medical Claims

   When the Plan Participant receives other medical services from clinics, Provider offices, etc., he should ask if the Provider is a Network Provider. If yes, this Provider will file the Plan Participant's Claim with the Claims Administrator. In some situations, the Non-Network Provider may request payment and ask the Plan Participant to file. If this occurs, the Plan Participant must be sure the claim form is complete before forwarding it to the Claims Administrator.

   If the Plan Participant is filing the Claim, the Claim must contain the information listed in section B., above.

   Itemized bills submitted with claim forms must include the following:

   a. full name of patient

   b. date(s) of service

   c. all services itemized, with the appropriate diagnosis and procedure codes and descriptions, for each service/treatment rendered, along with the charge for each service/treatment rendered

   d. name and address of Provider of service.

   NOTE: Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills.

D. If Plan Participant Has a Question About His Claim

Plan Participants can view information about the processing or payment of a claim online at **www.bcbsla.com**.

If a Plan Participant has a question about the payment of a Claim, the Plan Participant can write to the Claims Administrator at the address below or the Plan Participant may call the Claims Administrator's customer service department at the telephone number shown on his ID card or any of the Claims Administrator's local service offices*. If the Plan Participant calls for information about a Claim, the Claims Administrator can help the Plan Participant better if the Plan Participant has the information at hand, particularly the Plan Participant ID number, patient's name and date of service.

Blue Cross and Blue Shield of Louisiana
5525 Reitz Avenue
P.O. Box 98027
Baton Rouge, LA 70898-9029

Remember, the Plan Participant must ALWAYS refer to the his Plan Participant ID number in all correspondence and recheck it against the Plan Participant ID number on his ID card to be sure it is correct.

* Blue Cross and Blue Shield of Louisiana has local service offices located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

ARTICLE XXI. RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator Responsibility

The OGB will administer the Plan in accordance with its terms, state and federal law, the OGB's established policies, interpretations, practices, and procedures. The OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding eligibility for benefits and to decide disputes which may arise relative to a Covered Person's rights.

B. Amendments to or Termination of the Plan

OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Employee, whether active or retired.

C. Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to the Plan Participants, and defraying reasonable expenses of administering the Plan. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation.

D. The Claims Administrator is not a Fiduciary

A Claims Administrator is NOT a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

GENERAL PLAN INFORMATION

NAME OF PLAN:	Consumer Driven Health Plan for State of Louisiana Employees
PLAN ADMINISTRATOR:	State of Louisiana Office of Group Benefits Post Office Box 44036 Baton Rouge, Louisiana 70804 (800) 272-8451
PLAN NUMBER (PN):	501
TYPE OF PLAN:	Group Major Medical Benefit Plan
TYPE OF ADMINISTRATION:	The Plan is a self-funded Group Health Plan. Benefits are administered, on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administrative Services Agreement and the terms and conditions of the Benefit Plan.
CLAIMS ADMINISTRATOR:	Blue Cross and Blue Shield of Louisiana (BCBSLA) 5525 Reitz Avenue Baton Rouge, LA 70809 (800) 392-4089 BCBSLA has been retained to process claims under the Plan. BCBSLA does not serve as an insurer, but merely as a claims processor. Claims for Benefits are sent to BCBSLA. BCBSLA processes and pays claims, then requests reimbursement from Plan. State of Louisiana, Office of Group Benefits is ultimately responsible for providing Plan Benefits, and not BCBSLA.
PLAN YEAR ENDS:	December 31
PLAN DETAILS:	The eligibility requirements, termination provisions, Covered Services and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any Benefits are described in the Benefit Plan.
FUTURE OF THE PLAN:	Although the Plan Administrator expects and intends to continue the Benefit Plan indefinitely, the Plan Administrator reserves the right to modify, amend, suspend, or terminate the Benefit Plan at any time.

GENERAL NOTICE OF CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under certain circumstances when coverage would otherwise end under any of the Office of Group Benefits-sponsored health plans (hereinafter referred to as "Plan"). **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered by the State of Louisiana (such as life insurance).

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your Spouse and Dependent Children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should get a copy of the Plan Document from the Plan. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Office of Group Benefits, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your Spouse, and your Dependent Children could become qualified beneficiaries and would be entitled to elect COBRA coverage if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted Children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay the entire cost of COBRA coverage.

Who is entitled to elect COBRA Coverage?

If you are an Employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your Spouse. Also, if your Spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce. If you notify the Office of Group Benefits within 60 days after the divorce and can establish that the Employee cancelled the coverage earlier in anticipation of the divorce, the COBRA coverage may be available for the period after the divorce.

A person enrolled as the Employee's Dependent Child will be entitled to elect COBRA coverage, if he or she loses group health coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child."

When is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries only after the Office of Group Benefits has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the Employee, the Participant Employer must notify the Office of Group Benefits of the qualifying event within 30 days following the date coverage ends.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the Employee and Spouse, or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Office of Group Benefits in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You must follow the notice procedures specified by the Office of Group Benefits. If notice is not provided to the Office of Group Benefits during the 60-day notice period, ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

Once the Office of Group Benefits receives timely notice of the qualifying event, it will forward the information to its third-party COBRA Administrator, who will notify You of your right to elect COBRA coverage.

Electing COBRA

Once the Office of Group Benefits receives timely notice that a qualifying event has occurred, each qualified beneficiary will have an independent right to elect COBRA coverage. Once the Office of Group Benefits receives timely notice of the qualifying event, it will forward the information to its third-party COBRA Administrator, who will notify You of your right to elect COBRA coverage. Covered Employees and Spouses (if the Spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their Children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the covered Employee's divorce, or a Dependent Child's losing eligibility as a Dependent Child, COBRA coverage can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage under the Plan for his Spouse and Children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction in hours.

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Extension of COBRA Coverage

The COBRA coverage periods described above are maximum coverage periods. There are two ways in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration (or by the staff of the COBRA Administrator in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment) to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered Employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first (61st) day after the Covered Employee's termination of employment or reductions of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

For persons eligible to receive Social Security disability benefits, the disability extension is available only if you notify the Office of Group Benefits and the COBRA Administrator in writing and submit a copy of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", the disability extension is available only if you submit to the COBRA Administrator in writing proof of total disability before the initial 18-month COBRA coverage period ends.

You must also provide this notice to the COBRA Administrator within 18 months after the covered Employee's termination of employment or reduction in hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" (you may obtain a copy of this form from the COBRA Administrator at no charge, or you can download the form at **www.discoverybenefits.com**), **and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period and within 18 months after the Employee's termination of employment or reduction of hours, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving 18 months of COBRA coverage because of the covered Employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the Spouse and Dependent Children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the Spouse and any Dependent Children receiving COBRA coverage if the Employee or former Employee dies, or gets divorced, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered Employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of:

- the date of the second qualifying event; and
- the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still an Employee covered under the Plan).

In providing this notice, you must use the COBRA Administrator's form, entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from the COBRA Administrator at no charge, or you can download the form at **www.discoverybenefits.com**), **and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator within the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered Employee during COBRA coverage period

A Child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The Child's COBRA coverage begins on the Child's date of birth, date of adoption, or date of placement for adoption if the Child is enrolled in the Plan through the HIPAA Special Enrollment process designated by OGB, or on the first day of the following Plan year if the Child is enrolled through Annual Enrollment. The COBRA coverage lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A Child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Office of Group Benefits during the covered Employee's period of employment with the Participant Employer is entitled to the same rights to elect COBRA as an eligible Dependent Child of the covered Employee.

Health Insurance Marketplace

There may be other coverage options for you and your family. Through the Affordable Care Act, You are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and Out-of-Pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity with another group health plan for which you are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you must keep the Office of Group Benefits and the COBRA Administrator informed of any changes in your address and the addresses of your covered family members. You should also keep a copy, for your records, of any notices you send to the Office of Group Benefits and/or the COBRA Administrator.

Plan Contact Information

You may obtain information about the Plan and COBRA coverage on request from:

Plan Information:	**Office of Group Benefits** **Eligibility Department** **Post Office Box 44036** **Baton Rouge, Louisiana 70804** **1.800.272.8451** **225.342.9917 FAX**
COBRA Information:	Discovery Benefits, Inc. P.O. Box 2079 Omaha, NE 68103-2079 1.866.451.3399

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this notice, and you may obtain copies from the COBRA Administrator without charge or download them at **www.discoverybenefits.com**). Oral notice, including notice by telephone, is not acceptable. Electronic e-mailed notices are not acceptable.

How, When, and Where to Send Notices: You must mail or FAX your notice to:

Discovery Benefits, Inc.
P.O. Box 2079
Omaha, NE 68103-2079
1.855.678.1733 (Fax)

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If Faxed, your notice must be received by the Eligibility department at the number specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of COBRA coverage," and "Second qualifying event extension of COBRA coverage.")

Information Required for All Notices: Any notice you provide must include: (1) the name of the Plan; (2) the name and address of the Employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Notice Procedures (continued)

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce, your notice must include a copy of the decree of divorce. If your coverage is reduced or eliminated and later a divorce occurs, and if you are notifying the Office of Group Benefits that your Plan coverage was reduced or eliminated in anticipation of the divorce, your notice must include evidence satisfactory to the Office of Group Benefits that your coverage was reduced or eliminated in anticipation of the divorce.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination, if applicable; (5) a copy of the Social Security Administration's determination, if applicable; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled. For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", any notice of disability must also include proof of total disability, such as medical evidence presented by the applicant's physicians and the applicant's work history.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce, a copy of the decree of divorce.

Who May Provide Notices: The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Office of Group Benefits
Health Reimbursement Arrangement
For
State of Louisiana Plan Participants

provided by

Louisiana

5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802
www.bcbsla.com

40HR2025 R01/21

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

NOTICE TO ELIGIBLE EMPLOYEES, RETIREES AND DEPENDENTS

This Health Reimbursement Arrangement Plan (the "HRA" or the "Plan") is established by OGB to reimburse you for certain healthcare expenses as described herein. This HRA is integrated with a High Deductible Health Plan specifically designed to work with it. You cannot receive reimbursements from this HRA if you are not enrolled in its integrated High Deductible Health Plan. The HRA will reimburse you for those benefits covered under the High Deductible Health Plan but not reimbursable because they are adjudicated towards the plan's deductible or coinsurance. Healthcare services reimbursable under this HRA may be rendered to you by providers that either participate or not in the High Deductible Health Plan's network. However, to obtain the best advantage of your HRA funds, you should procure your healthcare services from providers that participate in the integrated High Deductible Health Plan's network.

Specific information about Network providers can be found at **http://www.bcbsla.com/ogb** or by calling the customer service telephone number on the back of your identification (ID) card.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

TABLE OF CONTENTS

ARTICLE I. INTRODUCTION

A. Establishment of the Plan

The Office of Group Benefits ("Plan Administrator") hereby establishes this Health Reimbursement Arrangement Plan (the "HRA" or the "Plan") effective January 1, 2015 (the "Effective Date"). This Plan is integrated with a Consumer Driven Health Plan (the "CDHP"), a High Deductible Health Plan specifically designed to work together with this HRA, and shall be administered accordingly. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is intended to permit a Participant to obtain reimbursement of Qualified Medical Expenses on a nontaxable basis from his or her HRA Account.

B. Legal Status

This Plan is intended to be a Health Reimbursement Arrangement (HRA) as defined under Internal Revenue Service (IRS) Notice 2002-45. The Qualified Medical Expenses reimbursed under this HRA are intended to be eligible for exclusion from a Participant's gross income under the Internal Revenue Code (IRC) Section 105(b). This Plan is intended to be an employer-provided medical reimbursement plan under IRC Sections 105 and 106 and regulations issued thereunder, and to satisfy the minimum value method of integration described in IRS Notice 2013-54 and U.S. Department of Labor (DOL) Technical Release (Tech. Rel.) 2013-3, through integration with the CDHP. This Plan and the integrated CDHP shall be interpreted to accomplish these objectives.

ARTICLE II. DEFINITIONS

Accrual – The funds that the Plan Administrator credit to each Participant's HRA Account at the beginning of the Period of Coverage, and are made available for the reimbursement of covered Qualified Medical Expenses.

Adverse Benefit Determination – Means denial or partial denial of a Benefit, in whole or in part, based on:

A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment determined to be experimental or investigational;

B. the Plan Participant's eligibility to participate in the Benefit Plan;

C. any prospective or retrospective review determination; or

D. a Rescission of Coverage.

Appeal – A written request from a Plan Participant or authorized representative to change an Adverse Benefit Determination made by the Claims Administrator.

Available Amount – The dollar amount available in a Plan Participant's HRA Account at any specific point in time for reimbursement of Qualified Medical Expenses, which will be the Accrual credited for the current Period of Coverage, plus any Carryover from a preceding Period of Coverage, reduced by prior reimbursements debited against the account.

Benefits – The Qualified Medical Expenses that are reimbursable under this Plan as described under Article VI.

Care Coordination – Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Plan Participant's healthcare needs across the continuum of care.

Care Coordinator Fee – A fixed amount paid by Blue Cross and Blue Shield of Louisiana to Providers periodically for Care Coordination under a Value-Based Program.

Carryover – Funds that are leftover in a Participant's HRA Account at the end of a Period of Coverage after all reimbursements for that Period of Coverage have been made, which are allowed under this Plan to be carried over to the next Period of Coverage.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Compensation – The wages or salary or retiree pension benefits paid to an Employee or Retiree by the Employer.

CDHP – The Consumer Driven Health Plan with which this HRA is integrated. It is a High Deductible Health Plan sponsored by OGB and intended to work together with this HRA.

Covered Person – An Eligible Employee or Retiree, or any of their Dependents eligible for coverage for whom the necessary application forms have been completed, and whom the Plan Administrator has accepted and enrolled into the Plan.

Date Acquired – The date a Dependent of a covered Employee/Retiree is acquired in the following instance and on the following dates only:

A. Spouse–the date of marriage;

B. Child or Children

1. Natural Children –the date of birth

2 Children placed for adoption with the Employee/Retiree:

Agency adoption – the date the adoption contract was executed between the Employee/Retiree and the adoption agency;

Private adoption–the date the Act of Voluntary Surrender is executed in favor of the Employee/Retiree. The Plan Administrator must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;

3. Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship –the date of the court order granting legal custody or guardianship;

4. From date of court order of filiation declaring paternity or date of formal acknowledgment of the Child;

5. Stepchild – the date of the marriage of the Employee/Retiree to his/her Spouse.

Dependent – Any of the following persons who (a) are enrolled for coverage as Dependents by completing appropriate enrollment documents, if they are not also covered as an Employee/Retiree, and (b) whose relationship to the Employee/Retiree has been documented, as defined here in:

A. The covered Employee's/Retiree's Spouse;

B. A Child from Date Acquired until end of month of attainment of age twenty-six (26), except for the following:

1. A grandchild or dependent of a dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which grandchild or dependent of a dependent was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until end of month the parent Dependent Child is no longer enrolled on or eligible to participate in the Plan, the end of the month the grandchild or dependent of a dependent turns twenty-six (26), or the grandchild or dependent of a dependent no longer meets the eligibility requirements under this Plan, whichever is earlier;

2. A child for whom the Employee/Retiree has current provisional custody and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which child was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until the end of the month of the 2016 anniversary date of the existing provisional custody document, the end of the month the child reaches the age of eighteen (18), or December 31, 2016, whichever is earlier;

3. A Child, who is not the Child or grandchild or the Employee/Retiree, for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship but who has not been adopted by the Employee/Retiree, from Date Acquired until the end of the month the custody/guardianship order expires or the end of the month the Child reaches the age of eighteen (18), whichever is earlier;

4. A stepchild of the Employee/Retiree, which stepchild has not been adopted by the Employee/Retiree and for whom the Employee/Retiree does not have court-ordered legal custody, until the earliest of:

    a. The end of the month the Employee/Retiree is no longer married to the stepchild's parent;

    b. The end of the month of the death of the Employee's/Retiree's Spouse who is the stepchild's parent; or

    c. The end of the month the stepchild attains the age of twenty-six (26).

C. A Child of any age who meets the criteria set forth in the Eligibility Article of this Benefit Plan.

Effective Date – The date when the Plan Participant's coverage begins under this Health Reimbursement Arrangement Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 AM on this date.

Electronic Protected Health Information – Has the meaning described in 45 CFR §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

Eligible Employee – An Employee eligible to participate in this HRA, as provided in Section 3.1.

Employee – A full-time Employee as defined by the respective Participant Employer in accordance with state law, and any Full-Time Equivalent.

Employment Commencement Date – The first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

Enrollment Form – The form provided by the Plan Administrator for the purpose of allowing a person to participate in this Plan.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Expedited Appeal – A request for immediate internal review of an Adverse Benefit Determination, which involves any of the following situations:

A. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function.

B. In the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

C. Decision not to Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

Expedited External Appeal – A request for immediate review, by an Independent Review Organization (IRO), of an initial Adverse Benefit Determination, which involves any of the following:

A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function, or a decision not to Authorize continued services for Plan Participants currently in the emergency room, under observation, or receiving Inpatient care.

B. A denial of coverage based on a determination the recommended or requested healthcare service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Plan Participant's health, including severe pain, potential loss of life, limb or major bodily function.

External Appeal – A request for review by an Independent Review Organization (IRO), to change an initial Adverse Benefit Determination made by the Company or to change a final Adverse Benefit Determination rendered on Appeal. External Appeal is available upon request by the Plan Participant or authorized representative for Adverse Benefit Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission of Coverage.

FMLA – The Family and Medical Leave Act of 1993, as amended.

Full Time Equivalent (FTE) – A full-time equivalent Employee who is employed on average 30 or more hours per week, as defined under IRC Section 4980H and determined pursuant to the regulations issued thereunder.

Health FSA – A health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-5(a) (1).

Highly Compensated Individual - An individual defined under IRC Section 105(h), as amended, as a "highly compensated individual."

HIPAA – The Health Insurance Portability and Accountability Act of 1996 (United States Public Law 104-191) and Federal Regulations promulgated pursuant thereto.

HRA – A health reimbursement arrangement as defined in IRS Notice 2002-45.

HRA Account(s) – The HRA Accounts described in Article IV (B).

IRC – The Internal Revenue Code of 1986, as amended.

Independent Review Organization (IRO) – An Independent Review Organization, not affiliated with Us, which conducts external reviews of final Adverse Benefit Determinations. The decision of the IRO is binding on both the insured and the Company.

IRS – The U.S. Internal Revenue Service.

Negotiated Arrangement ("Negotiated National Account Arrangement") – An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard® Program.

Office of Group Benefits (OGB) – The entity created and empowered to administer the programs of benefits authorized or provided for under the provisions of Chapter 12 of Title 42 of the Louisiana Revised Statutes.

Over-Age Dependent – A Dependent Child (or Grandchild) who is age 26 or older, reliant on Employee for support, and is incapable of sustaining employment because of an mental or physical disability that began prior to age 26. Coverage of the Over-Age Dependent may continue after age 26 for the duration of incapacity if, prior to the Dependent Child reaching age 26, an application for continued coverage with current medical information from the Dependent Child's attending Physician is submitted to the Plan. The Plan may require additional or periodic medical documentation regarding the Dependent Child's mental or physical disability as often as it deems necessary, but not more frequently than once a year after the two year period following the child's 26th birthday. The Plan may terminate coverage of the Over-Age Dependent if the Plan determines the Dependent Child is no longer reliant on Employee for support or is no longer mentally or physically disabled to the extent he is incapable of sustaining employment.

Period of Coverage – The Plan Year, with the following exceptions: (a) for Eligible Employees or Retirees who first become Participants, it shall mean the portion of the Plan Year following the date participation commences; and (b) for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation in the Plan terminates. A different Period of Coverage (e.g., a calendar month) may be established by the Plan Administrator and communicated to Participants.

Pharmacy Benefit Manager (PBM) – A third party administrator of Prescription Drug programs.

Plan – This HRA as set forth herein and as amended from time to time.

Plan Administrator – The Office of Group Benefits, who administers these Benefits on behalf of the State of Louisiana**,** for eligible Employees, Retirees and Dependents for Participant Employers.

Plan Participant – An Eligible Employee or Retiree, his eligible Dependent(s), or any other individual eligible for coverage under the Schedule of Eligibility or state or federal law for whom the necessary application forms have been completed, for whom the required contribution has been made, and for whom the Plan Administrator has accepted Eligibility and enrolled into the Plan. The term Plan Participant, defined here, is used interchangeably with the term Covered Person.

Plan Participant Employer – A State of Louisiana entity, school board, or a state political subdivision authorized by law to participate in this HRA.

Plan Year – The period from January 1, or the date the Plan Participant first becomes covered under the Plan, through December 31.

Privacy Official – Shall have the meaning described in 45 CFR §164.530(a).

Protected Health Information – Shall have the meaning described in 45 CFR §160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

Provider Incentive – An additional amount of compensation paid to a healthcare Provider by a payer, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group or population of covered persons.

Qualified Medical Expenses – Expenses incurred by a Covered Person for medical items and services that are deductible from the Participant's gross income under IRC Section 213 and IRS Publication 502.

Rescission of Coverage – Cancellation or discontinuance of coverage that has retroactive effect. This includes a cancellation that treats a Plan Participant's coverage as void from the time of the Group's enrollment or a cancellation that voids benefits paid up to one year before the cancellation.

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Plan) within thirty (30) days of experiencing a HIPAA Special Enrollment Event, including but not limited to, losing other comparable health coverage under certain circumstances enumerated by Law (unless a longer period is required by applicable Law) or acquiring a new Dependent as a result of marriage, birth, adoption or placement for adoption.

Spouse – The Employee's Spouse pursuant to a marriage recognized under state law where the marriage was entered.

Temporary Employee – An Employee who is employed for 120 consecutive calendar days or less.

USERRA – The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Value-Based Program (VBP) – An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

ARTICLE III. SCHEDULE OF ELIGIBILITY

Eligibility requirements for the OGB health plans apply to all participants in OGB-sponsored health plans and the OGB life insurance plan.

THE PLAN ADMINISTRATOR HAS FULL DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR COVERAGE/BENEFITS AND/OR TO CONSTRUE THE TERMS OF THIS PLAN.

NOTE: A Temporary Employee does not meet the Eligibility Requirements under this Benefit Plan, unless such Temporary Employee is determined to be a FTE.

A. Persons to be Covered

1. Employee

   a. A full-time Employee as defined by a Participant Employer and any FTE, both as determined in accordance with applicable state and federal law.

   b. Spouse, Both Employees/Retirees - NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE/RETIREE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE/RETIREE. If a covered Spouse is eligible for coverage as an Employee/Retiree and chooses to be covered separately at a later date, that person will be a covered Employee/Retiree effective the first day of the month after the election of separate coverage. The change in coverage will not increase Benefits.

   c. Effective Dates of Coverage, New Employee, Transferring Employee, and FTE

      Coverage for each Employee who completes the applicable enrollment form and agrees to make the required payroll contributions to his Participant Employer is effective as follows:

      (1) For new full-time Employees, if employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if hired on July 1st, coverage will begin on August 1st).

      (2) For new full-time Employees, if employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15th, coverage will begin on September 1st).

      (3) Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

      (4) An Employee who transfers employment to another Participant Employer must complete a transfer form within thirty (30) days following the date of transfer to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

      (5) An Employee who is determined to be a FTE will be allowed to enroll in the Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth month of employment for those Employees determined to be FTEs during their initial measurement period.

(6) Employee coverage will become effective concurrent with the date employment begins when required by state law during a federal or state declaration of emergency involving risk to health of individuals employed by a public elementary or secondary school system.

d. Re-Enrollment for Health and/or Life Benefits

(1) Full-time Employees returning to full time or part-time status with less than thirteen (13) weeks (less than 26 weeks for educational institutions) since separation or termination may resume coverage if application is made within thirty (30) days following return to work. Coverage will resume on the first of the month following return to work.

(2) If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within thirty (30) days of re-employment.

e. Board and Commission Members

Except as otherwise provided by law, board and commission members are not eligible to participate in this Plan. This provision does not apply to members of school boards, state boards, or commissions as defined by the Participant Employer as full-time Employees.

f. Legislative Assistants

A legislative assistant is eligible to participate in the Plan if he or she is determined to be a full-time Employee by the Participant Employer under applicable federal and state law or pursuant to La.R.S. 24:31.5(C), and either:

- Receives at least sixty (60) percent of the total compensation available to employ the legislative assistant if the legislator Employer employs only one legislative assistant; or

- Is the primary legislative assistant as defined in La.R.S. 24:31.5(C) when a legislator Employer employs more than one legislative assistant.

2. Retiree Coverage-Eligibility

a. Retirees of Participant Employers are eligible for Retiree coverage under this Plan.

b. Retirees of Participant Employers may not be covered as an Employee.

c. Effective Date of Coverage - Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions. For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. For example, if date of retirement is July 15, retiree coverage will begin August 1; if date of retirement is August 1, retiree coverage will begin September 1.

3. Documented Dependent Coverage - Eligibility

a. Documented Dependent of an eligible Employee/Retiree will be eligible for Dependent coverage on the latest of the following dates:

(1) The date the Employee/Retiree becomes eligible;

(2) The Date Acquired for Employee's/Retiree's Dependents

b. Effective Dates of Coverage – Application for coverage must be made within thirty (30) days of eligibility for coverage.

(1) Documented Dependents of Employees/Retirees - Coverage will be effective on the Date Acquired.

c. NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE/RETIREE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE/RETIREE.

4. HIPAA Special Enrollment Events

Certain eligible persons may enroll in the Plan if they experience a HIPAA Special Enrollment Event as provided by federal law. HIPAA Special Enrollment Events include but are not limited to birth, adoption, placement for adoption, marriage, eligibility for premium assistance subsidy under Medicaid or State Children's Health Insurance Program (SCHIP) coverage, loss of other health coverage through divorce, legal separation, or annulment, and loss of eligibility based on termination of Medicaid or SCHIP coverage. Application to the Plan Administrator must be made within thirty (30) days of the HIPAA special enrollment event unless a longer period is provided by federal law or by OGB.

5. Other Special Enrollment or Disenrollment Events

Employees/Retirees may also change coverage outside of Annual Enrollment if they or an applicable eligible dependent experience an OGB Plan-Recognized Qualified Life Event that allows for a specific change in coverage and make timely application to the Plan Administrator for such. The OGB Plan-Recognized Qualified Life Events are subject to change at any time and can be found at **http://info.groupbenefits.org/qle/**.

6. Medicare Advantage Option for Retirees other than OGB-sponsored plans

Retirees who are eligible to participate in a Medicare Advantage plan sponsored by OGB who cancel coverage with the Plan upon enrollment in such a Medicare Advantage plan may re-enroll in the Plan upon withdrawal from or termination of coverage in the Medicare Advantage plan, during the next Annual Enrollment, for coverage effective at the beginning of the next Plan Year.

Retirees who elect to participate in a Medicare Advantage plan not sponsored by OGB will not be allowed to reenroll in a plan offered by OGB upon withdrawal from or termination of coverage in the Medicare Advantage plan.

7. TRICARE for Life Option for Military Retirees

Retirees eligible to participate in the TRICARE for Life (TFL) option on and after October 1, 2001, who cancel coverage with the Plan upon enrollment in TFL may re-enroll in the Plan in the event that the TFL option is discontinued or its Benefits significantly reduced.

B. Continued Coverage

1. Leave of Absence

a. Leave of Absence without Pay, Employer Contributions to Premiums

(1) A participating Employee who is granted leave of absence without pay due to a service related injury may continue coverage and the Participant Employer shall continue to pay its portion of health plan premiums for up to twelve (12) months if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

(2) A participating Employee who suffers a service related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the Participant Employer shall continue to pay its portion of the premium until the Employee becomes gainfully employed or is placed on state disability retirement.

(3) A participating Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the Participant Employer shall continue to pay its portion of premiums if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

b. Leave of Absence Without Pay - No Employer Contributions to Premiums

An Employee granted leave of absence without pay for reasons other than those stated in above in B.1., may continue to participate in an OGB Plan for a period up to twelve (12) months upon the Employee's payment of the full premiums due.

THE PARTICIPANT EMPLOYER AND THE EMPLOYEE MUST NOTIFY THE PLAN ADMINISTRATOR WITHIN THIRTY (30) DAYS OF THE EFFECTIVE DATE OF THE LEAVE OF ABSENCE.

2. Disability

a. Employees who have been granted a waiver of premium for Basic or Supplemental Life Insurance prior to July 1, 1984, may continue health coverage for the duration of the waiver if the Employee pays the total contribution to the Participant Employer. Disability waivers were discontinued effective July 1, 1984.

b. If a Participant Employer withdraws from the Plan, health and life coverage for all Covered Persons will terminate on the effective date of withdrawal.

3. Surviving Dependents/Spouse

a. Benefits under the Plan for covered Dependents of a deceased covered Employee/Retiree will terminate on the last day of the month in which the Employee's/Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

(1) The surviving Spouse of an Employee/Retiree may continue coverage unless or until the surviving Spouse is or becomes eligible for coverage in a group health plan other than Medicare.

(2) The surviving Dependent Child of an Employee/Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a group health plan other than Medicare or until end of the month of the attainment of the termination age for that specific Dependent Child, whichever occurs first.

(3) Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees/Retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits.

(4) Coverage provided by the Civilian Health and Medical Program for the Uniform Services (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving Spouse or a Dependent Child.

b. A surviving Spouse or Dependent cannot add new Dependents to continued coverage other than a Child of the deceased Employee/Retiree born after the Employee's/Retiree's death.

c. Participant Employer/Dependent Responsibilities

(1) The Participant Employer and/or surviving covered Dependent shall notify the Plan Administrator within thirty (30) days of the death of the Employee.

(2) The Plan Administrator will notify the surviving Dependents of their right to continue coverage.

(3) Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of notification, and premium payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.

(4) Coverage for the surviving Spouse under this section will continue until the earliest of the following:

(a) Failure to pay the applicable premiums, contributions and surcharges timely.

(b) Eligibility of the surviving Spouse under a group health plan other than Medicare.

(5) Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:

(a) Failure to pay the applicable premiums, contributions and surcharges timely.

(b) Eligibility of the surviving Dependent Child for coverage under any group health plan other than Medicare; or

(c) The end of the month of attainment of the termination age for that specific Dependent Child.

d. The provisions of paragraphs 3.a. through 3.c. above are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree.

Continued coverage for surviving Dependents that made such election before July 1, 1999, shall be governed by the rules in effect at the time of the election.

4. Over-Age Dependents

If a Dependent Child is incapable (and became incapable prior to attainment of age twenty-six (26) of self-sustaining employment, by reason of physical or mental disability, the coverage for the Dependent Child may be continued for the duration of incapacity.

a. No earlier than six (6) months prior to the Dependent Child reaching age twenty-six (26), an application for continued coverage must be filed with the Plan Administrator on a form designated by the Plan Administrator, with current medical information from the Dependent Child's attending Physician along with the Child's attending Physician's attestation of the Child's incapacity to perform self-sustaining employment, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.

b. After the initial approval, the Plan Administrator may require the submission of additional medical or other supporting documentation substantiating the continuance of the disability, but not more frequently than annually, as a precondition to continued coverage.

5. Military Leave

Employees of the National Guard or in the United States military reserves who are called to active military duty and their covered eligible Dependents will have access to continued coverage under OGB's health and life plans subject to submittal of appropriate documentation to OGB.

a. Health Plan Participation - When an Employee is called to active military duty, the Employee and his/her covered eligible Dependents may:

(1) continue participation in the health plan during the period of active military service, in which case the Participant Employer may continue to pay its portion of premiums; or

(2) cancel participation in the health plan during the period of active military service, in which case the Employee may apply for reinstatement of OGB coverage within thirty (30) days of:

(a) the date of the Employee's re-employment with a Participant Employer; or

(b) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Employees who elect this option and timely apply for reinstatement of OGB coverage, the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding rules promulgated by OGB.

C. COBRA

1. Employees

a. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

b. The Participant Employer shall notify the Plan Administrator within thirty (30) days of the date coverage would have terminated because of any of the foregoing events. OGB's third-party COBRA vendor ("COBRA Administrator") will notify the Employee within fourteen (14) days of such notification of his right to continue coverage.

c. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification, and premium payment must be made to the COBRA Administrator within forty-five (45) days of the date the Employee elects continued coverage. Continued Coverage will be retroactive to the date it would have otherwise terminated.

d. Coverage under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Eighteen (18) months from the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a Group Health Plan; or

(5) The Employer ceases to provide any group health plan for its Employees/Retirees.

e. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered Spouse and/or covered Dependent Children may elect to continue coverage at his own expense. The elected coverage will be subject to the above stated notification and termination provisions.

2. Surviving Dependents

a. Coverage under this Plan for covered surviving Dependents of an Employee/Retiree will terminate on the last day of the month in which the Employee's/Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.

b. The Participant Employer and/or surviving covered Dependents shall notify the Plan Administrator within thirty (30) days of the death of the Employee. The COBRA Administrator will notify the surviving Dependents of their right to continue coverage within 14 days of receipt of such notification. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification.

c. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for the surviving Dependents under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a Group Health Plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

3. Ex-Spouse/Ex-Stepchildren - Divorce, Annulment, Legal Separation or Death

a. Coverage under this Plan for an Employee's/Retiree's Spouse (and any stepchildren enrolled on the Plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment, or legal separation from the Employee/Retiree, unless the covered ex-Spouse elects to continue coverage at his/her own expense.

b. Coverage under this Plan for an Employee's/Retiree's stepchild will terminate on the last day of the month of the death of the Employee's/Retiree's Spouse who is the stepchild's parent.

c. The Employee/Retiree or the ex-spouse/ex-stepchild shall notify the Plan Administrator of the divorce, annulment, legal separation or death within sixty (60) days from the date of the divorce, annulment, legal separation or death. The COBRA Administrator will notify the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) within fourteen (14) days of his/her/their right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the election notification.

d. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

e. Coverage for the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

4. Dependent Children

a. Coverage under this plan for a covered Dependent Child will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent Child elects to continue coverage at his own expense.

b. The Dependent Child shall notify the Plan Administrator of his loss of eligibility within sixty (60) days of the date coverage would have terminated. The COBRA Administrator will notify the Dependent Child within fourteen (14) days of his/her right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of receipt of the election notification.

c. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for a Dependent Child under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

5. Dependents of COBRA Participants

a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered Spouse or a covered Dependent Child becomes ineligible for coverage due to:

(1) Death of the Employee,

(2) Divorce, Annulment, or Legal Separation from the Employee, or

(3) A Dependent Child no longer meets the definition of an eligible covered Dependent, then, the Spouse and/or Dependent Child may elect to continue COBRA coverage at his/her own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

b. The Spouse and/or the Dependent Child shall notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.

c. Monthly payments to the COBRA Administrator for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for the Spouse or Dependent Child under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a Group Health Plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

6. Disability COBRA

a. If a Plan Participant is determined by the Social Security Administration or by the COBRA Administrator staff (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient quarters of employment) to have been totally disabled on the date the Plan Participant became eligible for continued coverage or within the initial eighteen (18) months of continued coverage, coverage under this Plan may be extended at his own expense up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated.

b. To qualify for disability COBRA, the Plan Participant must:

(1) Submit a copy of his/her Social Security Administration's disability determination to the COBRA Administrator before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:

(a) The date of issuance of the Social Security Administration's disability determination; and

(b) The date on which the qualified beneficiary loses (or would lose) coverage under terms of the Plan as a result of the covered Employee's termination or reduction of hours.

(2) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of employment, submit proof of total disability to the COBRA Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the COBRA Administrator will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.

c. For purposes of eligibility for extended continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of twelve (12) months.

To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

d. Monthly payments to the COBRA Administrator for each month of extended disability COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

e. Coverage under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Twenty-nine (29) months from the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan;

(5) The Employer ceases to provide any group health plan for its Employees; or

(6) Thirty (30) days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Plan Administrator and the COBRA Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the COBRA Administrator determines that the Covered Person is no longer disabled.

7. Medicare COBRA

a. If an Employee becomes entitled to Medicare less than eighteen (18) months before the date the Employee's eligibility for Benefits under this Plan terminates, the period of continued coverage available for the Employee's covered Dependents will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months from the date of the Employee's Medicare entitlement;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees.

b. Monthly payments to the COBRA Administrator for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

8. Miscellaneous Provisions

When the Employee/Retiree will participate in COBRA continuation coverage with his/her Dependents which are qualified beneficiaries, the Employee/Retiree and those Dependents that elect COBRA will continue the same HRA Account that they had when the Employee/Retiree was active.

When the Employee/Retiree will not participate in COBRA continuation coverage with his/her Dependents, the qualified beneficiaries that elect COBRA will be set up in a separate HRA Account until the end of their continuation coverage. Such separate HRA Account will have its own Accrual based on enrollment status, and its own Carryover features. HRA Accounts set for these qualified beneficiaries will not carryover any portion of the Available Amount from the original HRA Account.

Otherwise, during the period of continuation of coverage, Benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Plan Participants.

D. Change of Classification

1. Adding or Deleting Dependents

When a Dependent is added to the Employee's/Retiree's coverage as a result of a HIPAA Special Enrollment Event or deleted from the Employee's/Retiree's coverage consistent with a change in status, application made by an active Employee shall be provided to the Employee's Human Resources liaison and application made by a Retiree shall be provided to OGB. Application is required to be made within thirty (30) days of the HIPAA Special Enrollment Event or change in status unless otherwise specified in this Plan document or unless a longer application period is required by federal or state law. When a Dependent is added to or deleted from coverage during an OGB-designated enrollment period, application is required to be made as directed by OGB for the designated enrollment period.

2. Change in Coverage

When the addition of a Dependent as a result of a HIPAA Special Enrollment Event results in a change in classification, the change in classification will be effective on the date of the HIPAA Special Enrollment Event.

3. Notification of Change

It is the Employee/Retiree's responsibility to make application for any change in classification of coverage.

E. Contributions

The State of Louisiana may make a contribution toward the cost of the Plan, as determined by the Legislature.

F. Medical Child Support Orders

A Dependent Child shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). Application must be made within thirty (30) days of the receipt of the QMCSO or NMSN. Coverage will be effective the first of the month following OGB's receipt of timely application and all required supporting documentation. An Employee who is not currently enrolled in an OGB Plan may enroll to effect coverage for his or her Dependent(s) who are the subject of the QMCSO.

A QMCSO is a state court order or judgment, including approval of a settlement agreement that:

1. Provides for support of a covered Plan Participant's Dependent Child;

2. Provides for healthcare coverage for that Dependent Child;

3. Is made under state domestic relations law (including a community property law);

4. Relates to Benefits under the Plan; and

5. Is "qualified" in that it meets the technical requirements of applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the Dependent Child of a non-custodial parent who is (or will become) a Covered Person by a domestic relations order that provides for healthcare coverage.

G. Termination of Coverage

Subject to continuation of coverage and COBRA rules, all benefits of a Plan Participant will terminate under this Plan on the earliest of the following dates:

1. The date the Plan terminates;

2. The date the Participant Employer terminates or withdraws from the Plan;

3. The date contribution is due if the Participant Employer fails to pay the required contribution;

4. The date contribution is due if the Plan Participant fails to make any contribution which is required for the continuation of coverage;

5. The last day of the month of the Plan Participant's death;

6. The last day of the month in which the Plan Participant ceases to be eligible as a Plan Participant.

ARTICLE IV. METHOD OF FUNDING

A. Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Plan Administrator. Nothing herein will be construed to require the Plan Administrator or any Participant Employer to maintain any fund or to segregate any amount for the benefit of any Covered Person, and no Covered Person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Plan Administrator or any Participant Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

B. Establishment of the Individual HRA Accounts

The Claims Administrator will establish and maintain an HRA Account with respect to each Participant but the Plan Administrator will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions, reimbursements and Available Amounts. HRA Accounts will be kept under the name of the Participant. Claims for any Dependents of the Participant will be paid out of the Participant's HRA Account. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Qualified Medical Expenses.

C. Contributions

All contributions to fund this Plan will come from the Plan Administrator. The Participant will not be allowed to make any kind of contributions to fund this Plan. Under no circumstances will this HRA or the HRA Accounts be funded with Compensations, employee contributions or through an IRC Section 125 Cafeteria Plan, nor will any Compensation reduction or contributions for other employer-sponsored plans or benefits be used or treated as Participant contributions to this Plan.

ARTICLE V. MANAGEMENT OF HRA ACCOUNTS

A. Accruals

The amount of funds that will be credited to each Participant's HRA Account ("Accrual") will depend on the enrollment of that Participant in the integrated CDHP at the moment that the Accrual is credited. Accruals will be as follows:

1. For Employee or Retiree only enrollment - $1,000.00 for the Plan Year.

2. For Employee or Retiree plus any Dependent enrollment ("Family") - $2,000.00 for the Plan Year.

The full amount of the Accruals will be credited at the beginning of each Period of Coverage. If during a Period of Coverage a Participant that started as an Employee or Retiree only upgrades his/her enrollment status to Employee or Retiree plus Family under the special enrollment rules that would allow the Participant to make such an upgrade, the HRA Account will be credited with the difference in Accrual on the effective date of the change.

The Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of covered Qualified Medical Expenses incurred during the Period of Coverage.

B. Nondiscrimination

Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with IRC Section §105(h), as may be determined by the Plan Administrator in its sole discretion.

C. Carryovers from One Period of Coverage to the Next

If any balance remains in the Participant's HRA Account at the end of a Period of Coverage after all reimbursements have been made for that Period of Coverage, such balance shall be carried over to reimburse the Participant for Qualified Medical Expenses incurred during a subsequent Period of Coverage ("Carryover"), as long as the Participant reenrolls in the HRA and its integrated CDHP for such subsequent Period of Coverage. The balance to be carried over from one Period of Coverage to the next will never exceed the integrated CDHP's maximum out of pocket amount for in-network benefits that was effective for the previous CDHP's Plan Year. Any amount over this maximum Carryover will be forfeited at the end of the Period of Coverage.

D. Forfeitures

If an Eligible Employee or Retiree ceases to be a Participant of the HRA and its integrated CDHP for any reason, all Available Amounts in the HRA Account will be forfeited as of the date of termination. Expenses incurred after the Participant's termination date will not be reimbursed. The funds forfeited will not be available for the Participant or his/her Dependents for any future Period of Coverage under the HRA.

E. Reimbursement Procedure

The Claims Administrator will pay reimbursements out of the HRA Account when it adjudicates the claims under the integrated CDHP. The Covered Person will not have to submit a separate claim to receive reimbursements under the HRA. Claims must be submitted to the Claims Administrator under the integrated CDHP's procedures for Covered Persons to have access to the funds in the HRA Account.

Reimbursements under this HRA will be paid directly to the healthcare providers when under the terms of the integrated CDHP the claim is payable to the providers. Otherwise, the reimbursement under this

HRA will be paid to the person to whom the claim payment under the integrated CDHP is made.

F. Changes

For subsequent Plan Years, the Benefits, Accruals and Carryover limits, and any other terms and conditions of this HRA, may be changed by the Plan Administrator at its sole discretion, by notice to Employees and Retirees.

ARTICLE VI. HEALTH REIMBURSEMENT BENEFITS

A. Benefits

This Plan will reimburse Covered Persons for those Qualified Medical Expenses that are otherwise covered under the integrated CDHP but that are not reimbursed by the CDHP because they are adjudicated against the CDHP's deductible or a coinsurance amount that is the Covered Person's responsibility under the CDHP. Reimbursement will be made up to the Available Amount in the Participant's HRA Account at the time the claim is adjudicated under the integrated CDHP. Once the funds in the HRA Account are exhausted, no more Benefits will be paid for the Period of Coverage.

B. Incurral of Qualified Medical Expenses

A Covered Person may receive reimbursement under the HRA Account only for those covered Qualified Medical Expenses incurred during a Period of Coverage. A Qualified Medical Expense is incurred at the time the medical care, item or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Qualified Medical Expenses incurred before a Covered Person first becomes covered under the HRA, or after a Covered Person is terminated from the HRA, are not eligible for reimbursement.

C. Exclusions

This HRA will **not** reimburse Qualified Medical Expenses that are:

1. Health insurance premiums or contributions towards the cost of coverage for individual market health plans or for any other group health plan (including the integrated HDHC).

2. Pharmacy benefits covered under the integrated CDHP, whether prescribed or unprescribed.

3. Medications or drugs not covered under the integrated CDHP, whether prescribed or unprescribed.

4. Expenses for items or services excluded under the integrated CDHP.

5. Expenses for items or services determined to be not medically necessary or investigational under the integrated CDHP.

6. Expenses for routine vision services, eye exams, eyeglasses, frames or contact lenses.

7. Expenses for dental services, except those specifically covered under the medical portion of the integrated CDHP.

8. Expenses reimbursable under the integrated CDHP, or any other accident or health plan.

9. Expenses that are not specifically adjudicated towards the integrated CDHP's deductible or coinsurance.

D. Claims Prescription Period

Claims must be submitted to the Claims Administrator within twelve (12) months from the date that the expense is incurred, which is the date that the medical item or service was rendered ("Date of Service"). Qualified Medical Expenses will not be reimbursed under this HRA if the claim is submitted after this period.

ARTICLE VII. COORDINATION OF BENEFITS

Benefits under this Plan are solely intended to reimburse the covered Qualified Medical Expenses not previously reimbursed or reimbursable elsewhere. When the Covered Person has more than one health plan, this HRA will follow its integrated CDHP in its Coordination of Benefits and will pay Benefits only for those not otherwise reimbursed deductible or coinsurance amounts left over once the CDHP has finished adjudicating its claims.

When the Covered Person is entitled to reimbursement of a Qualified Medical Expense under this HRA and a Health Flexible Spending Arrangement (Health FSA) sponsored by the Plan Administrator, this HRA will pay its benefits first. Qualified Medical Expenses that are reimbursable under this HRA and also a Health FSA will only be reimbursed by the Health FSA after the funds of the Participant's HRA Account have been exhausted.

ARTICLE VIII. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP AND ALL COVERED PERSONS. THE GROUP IS THE PLAN ADMINISTRATOR FOR THIS PLAN.

BLUE CROSS AND BLUE SHIELD OF LOUISIANA PROVIDES ADMINISTRATIVE CLAIMS SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

A. This Plan

1. To the extent that this Benefit Plan may be an Employee welfare Benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the Plan Administrator of such Employee welfare Benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those that the Claims Administrator specifically undertake herein. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to Plan Participants for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or in the case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group's failure to do so.

2. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.

3. The (Plan Administrator) shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and

interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

4. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.

5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

6. Except as specifically provided herein, this Benefit Plan will not make the Claims Administrator liable or responsible for any duty or obligation that is imposed on the Employer by federal or state law or regulations.

7. The Plan Administrator will not discriminate on the basis of race, color, religion, national origin, disability, sex, age, protected veteran or disabled status or genetic information; and shall not impose eligibility rules or variations in premium based on a Plan Participant's health status or a health status-related factor.

B. Amending and Terminating the Plan

OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Participant, whether active or retired.

Any provision of the Plan which, on its Effective Date, is in conflict with applicable state law provisions (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

C. Employer Responsibility

1. The Participant Employer shall submit enrollment and change forms and all other necessary documentation to the Plan Administrator on behalf of its Participants. Employees of a Participant Employer will not, by virtue of furnishing any documentation to the Plan Administrator, be considered agents of the Plan Administrator, and no representation made by any such person at any time will change the provisions of this Plan.

2. A Participant Employer shall immediately inform the Plan Administrator when a Retiree with OGB coverage returns to full-time employment. The Retiree shall be placed in the Re-employed Retiree category for premium calculation. The Re-employed Retiree premium classification applies to Retirees with and without Medicare. The premium rates applicable to the Re-employed Retiree premium classification shall be identical to the premium rates applicable to the classification for Retirees without Medicare.

3. A Participant Employer who receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the OGB MSP Adjuster within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties

due to Medicare for a Covered Person. If not timely forwarded, OGB will assume responsibility only for covered Plan benefits due to Medicare for a Covered Person. The Participant Employer will be responsible for interest, fines, and penalties due.

D. Benefits To Which Covered Persons are Entitled

1. The liability of the Plan Administrator is limited to the Benefits specified in this Plan. If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

2. Reimbursements for covered Benefits specified in this Plan will be provided only for services and supplies rendered on and after the Covered Person's Effective Date of coverage.

E. Retroactive Cancellation of Coverage

1. The Plan Administrator may retroactively cancel coverage in the following instances:

   a. To the extent the cancellation of coverage is attributable to a failure of the Plan Participant to timely pay required premiums, contributions and surcharges toward the cost of coverage; or

   b. The cancellation of coverage is initiated by the Plan Participant.

2. When the Plan Administrator retroactively cancels coverage, the Plan Participant shall be liable to the Plan Administrator for all benefits paid on behalf of the Plan Participant after the effective date of rescission or cancellation of coverage.

F. Termination of a Covered Person's Coverage Due to Fraud

The Plan may choose to rescind coverage or terminate a Covered Person's coverage if a Covered Person performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment form. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed or covered individual, shall constitute an intentional misrepresentation of material fact. A Covered Person's coverage may be rescinded retroactively to the effective date of coverage, or terminated within three (3) years of the Covered Person's effective date, for fraud or intentional misrepresentation of material fact. The Plan will give the Covered Person sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If you enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

G. Reinstatement to Position Following Civil Service Appeal

Self-Insured Covered Persons

When coverage of a terminated Employee, who was a participant in a self-insured health plan, is reinstated by reason of a civil service appeal, coverage will be reinstated to the same level in the Plan retroactive to the date coverage terminated. The Employee and Participant Employer are responsible for the payment of all premiums for the period of time from the date of termination to the date of the final order reinstating the Employee to his position. The Plan is responsible for the payment of all eligible Benefits for charges incurred during this period. All claims for expenses incurred during this period must be filed with the Plan within 60 days following the date of the final order of reinstatement.

H. Release of Information

The Claims Administrator may request that the Covered Person or the provider furnish certain information relating to the Participant's claim for Benefits.

The Claims Administrator will hold such information, records, or copies of records as confidential except where in the Claims Administrator's discretion the same should be disclosed.

I. Covered Person/Provider Relationship

1. The selection of a provider is solely the Covered Person's responsibility.

2. The Claims Administrator and all network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. The Claims Administrator does not render healthcare services, but only makes payment, on behalf of the Plan, for Benefits which the Covered Person receives. The Plan and the Claims Administrator will not be held liable for any act or omission of any provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Covered Person while receiving care from any network provider or in any network provider's facilities. The Plan and the Claims Administrator have no responsibility for a provider's failure or refusal to render services to the Covered Person.

3. The use or non-use of an adjective such as network and non-network in referring to any provider is not a statement as to the ability of the provider.

J. Notice

Any notice required under this Plan must be in writing. Any notice required to be given to a Covered Person will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Covered Person or the Participant at his address as the same appears on the Plan Administrator's records. Any notice that a Participant is required to give to the Plan Administrator must be given at the Plan Administrator's address as it appears in this Plan. The Plan or a Participant may, by written notice, indicate a new address for giving notice.

K. Subrogation and Reimbursement

Upon payment of any eligible Benefits covered under this Plan, the Office of Group Benefits plan shall succeed and be subrogated to all rights of recovery of the Plan Participant or his/her heirs or assigns for whose benefit payment is made and the Plan Participant shall execute and deliver instruments and papers and do whatever is necessary to secure such rights and shall do nothing to prejudice such rights. The Office of Group Benefits shall have an automatic lien against and shall be entitled, to the extent of any payment made to a Plan Participant and/or his/her heirs or assigns, to 100% of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a Plan Participant and/or his/her heirs or assigns against any person or entity legally responsible for the disease, illness, accident, or injury for which said payment was made.

To this end, Plan Participants agree to immediately notify the Office of Group Benefits or its agent assigned to exercise reimbursement and subrogation rights on its behalf of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident, or injury. These subrogation and reimbursement rights also apply, BUT ARE NOT LIMITED TO, when a Plan Participant recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

Under these subrogation and reimbursement rights, the Office of Group Benefits has a right of first recovery to the extent of any judgment, settlement, or any payment made to the Plan Participant and/or his/her heirs or assigns. These rights apply whether such recovery is designated as payment for pain and suffering, medical benefits, or other specified damages, even if the Plan Participant is not made whole (i.e., fully compensated for his/her injuries).

L. Right of Recovery

Whenever any payment for Benefits has been made by the Plan, in an amount that exceeds the maximum Benefits available for such services under this Plan, or exceeds the Allowable Charge, or whenever payment has been made in error by the Plan for non-covered services, the Plan will have the right to recover such payment from the Participant, the Dependent, or if applicable, the provider.

As an alternative, the Plan reserves the right to deduct, from any pending claim for payment under this Plan, any amounts the Covered Person or provider owes the Plan.

M. Coverage in a Department of Veterans Affairs or Military Hospital

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from the Plan to the extent the veteran would be eligible for Benefits for such care or services from the Plan if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

The United States will have the right to collect from the Plan the reasonable cost of healthcare services incurred by the United States on behalf of a military Participant or a military Dependent through a facility of the United States military to the extent that the Participant or Dependent would be eligible to receive reimbursement or indemnification from the Plan if the Retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

N. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a contract solely between the Plan Administrator and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Blue Cross and Blue Shield of Louisiana and its subsidiaries and affiliates (collectively “Blue Cross and Blue Shield of Louisiana”), to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Plan Administrator, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Plan Administrator for any of Blue Cross and Blue Shield of Louisiana's obligations to the Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of the claims administration agreement.

O. Out-of-Area Services

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”). Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever you obtain healthcare services outside the geographic area Blue Cross and Blue Shield of Louisiana serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Blue Cross and Blue Shield of Louisiana’s service area, you will receive it from one of two kinds of Providers. Most Providers (“Participating Providers”) contract with

the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. The Claims Administrator explains below how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits when paid as medical Benefits, and those Prescription Drug Benefits or vision care Benefits that may be administered by a third party contracted by the Claims Administrator to provide the specific service or services.

1. BlueCard® Program

   Under the BlueCard® Program, when Plan Participants access covered healthcare services within the geographic area served by a Host Blue, Claims Administrator will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Network Providers.

   When you receive Covered Services outside Blue Cross and Blue Shield of Louisiana's service area and the Claim is processed through the BlueCard® Program, the amount you pay for the Covered Services is calculated based on the lower of:

   - the billed covered charges for your Covered Services; or
   - the negotiated price that the Host Blue makes available to The Plan.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for your Claim because they will not be applied after a Claim has already been paid.

2. Special Case: Value-Based Programs

   a. BlueCard® Program

      If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

   b. Negotiated (non-BlueCard® Program) Arrangements

      If the Claims Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, the Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

   Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

4. Non-Participating Providers Outside Blue Cross and Blue Shield of Louisiana's Service Area

   a. Plan Participant Liability Calculation

      When Covered Services are provided outside of Blue Cross and Blue Shield of Louisiana's service area by Non-Participating Providers, the amount you pay for such services will normally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Medical Services.

   b. Exceptions

      In certain situations, the Claims Administrator may use other payment methods, such as billed charges for Covered Services, the payment the Claims Administrator would make if the healthcare services had been obtained within Blue Cross and Blue Shield of Louisiana's service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services provided by Non-Participating Providers. In these situations, you may be liable for the difference between the amount that the Non Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

5. Blue Cross Blue Shield Global® Core

   If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard® service area"), you may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core Program is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard® service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

   If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, you should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

   a. Inpatient Services

      In most cases, if you contact the Blue Cross Blue Shield Global® Core Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your Deductible and Coinsurance. In such cases, the Hospital will submit your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. You must contact the Claims Administrator to obtain Authorization for non-

Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

b. Outpatient Services

Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

c. Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for Covered Services outside the BlueCard® service area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of your Claim. The claim form is available from Blue Cross and Blue Shield of Louisiana, the Blue Cross Blue Shield Global® Core service center, or online at **www.bcbsglobalcore.com**. If you need assistance with your Claim submission, you should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

P. Compliance with HIPAA Privacy Standards

The Plan Administrator's workforce performs services in connection with administration of the Plan. In order to perform these services, it is necessary for these workforce members, from time to time, to have access to Protected Health Information (as defined below).

Under the Standards of Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these workforce members are permitted to have such access subject to the following:

1. General

The Plan shall not disclose Protected Health Information to any member of the Plan Administrator's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or Mental Health condition of a Covered Person, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

Protected Health Information disclosed to members of the Covered Person's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and healthcare operations. The terms "payment" and "healthcare operations" shall have the same definitions as set out in the Privacy Standards, the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of Benefits or reimbursement for healthcare. "Healthcare Operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of healthcare providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

3. Authorized Workforce Members

   The Plan shall disclose Protected Health Information on to members of the Plan Administrator's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan

   For purposes of this HIPAA Privacy section, "members of the Plan Administrator's workforce" shall refer to all workforce members and other persons under the control of the Plan Administrator.

   a. Updates Required. The Plan Administrator shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

   b. Use and Disclosure Restricted. An authorized workforce member of the Plan Administrator's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

   c. Resolution of Issues of Noncompliance. In the event that any member of the Plan Administrator's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

      (1) investigating the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

      (2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach may include oral or written reprimand, additional training or termination of employment;

      (3) mitigating any harm caused by the breach, to the extent practicable; and

      (4) documenting the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Plan Administrator

   The Plan Administrator agrees to:

   a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

   b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Administrator with respect to such information;

   c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Plan of the Plan Administrator;

   d. report any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

   e. make available Protected Health Information to individual Covered Persons in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Covered Persons and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. make available Protected Health Information required to provide any accounting of disclosures to individual Covered Persons in accordance with Section 164.528 of the Privacy Standards;

h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. if feasible, return or destroy all Protected Health Information in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. ensure the adequate separation between the Plan and Covered Person of the Plan Administrator's workforce, as required by Section 164.504 (f) (2) (iii) of the Privacy Standards.

The following State of Louisiana, Office of Group Benefits workforce members are authorized to receive Protected Health Information in order to perform the following duties:

- Customer Service
- Agency Services
- Eligibility Services
- Executive Staff Services
- Contract Management Services
- IT Services
- Legal Services
- Medical Director Consultation Services
- Payment Services

Q. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan Administrator agrees to the following:

1. The Plan Administrator agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Plan Administrator creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Plan Administrator shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Plan Administrator shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA

Privacy Standards sections (3) Authorized workforce members and (4) Certification of Plan Administrator described above in this Article.

R. Compliance with the Affordable Care Act

This Plan shall be operated and administered in compliance with the applicable provisions of the Affordable Care Act ("ACA"), including Code Section 4980H and the regulations promulgated thereunder. To the extent of any discrepancy between the terms of this Plan and the applicable requirements of the ACA, the Plan will be administered to comply with such applicable requirement.

ARTICLE IX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

OGB Eligibility Appeal Process

OGB retains the authority to make all determinations regarding eligibility, except for rescissions of coverage determinations and those determinations involving medical judgment regarding the incapacity of over-age 26 dependents. All other eligibility appeals must be submitted within 180 calendar days following the denial of coverage to State of Louisiana Office of Group Benefits, Post Office Box 44036, Baton Rouge, Louisiana 70804 (rather than Blue Cross and Blue Shield of Louisiana) and OGB shall have sixty (60), rather than thirty (30) calendar days in which to respond to the appeal. Rescissions of coverage determinations and those determinations regarding the incapacity of over-age 26 dependents shall be subject to the procedures set forth in Section C below.

Pharmacy Benefit Manager Appeals Process

Pharmacy Benefit Manager appeals information is available by calling MedImpact's Customer Contact Center at 800.788.2949 or by going to **www.groupbenefits.org**. Upon your written request, OGB will provide you a copy of the Pharmacy Benefit Manager appeals information at no charge.

A. COMPLAINTS AND GRIEVANCES: Quality of Care or Services

The Claims Administrator wants to know when a Plan Participant is dissatisfied with the quality of care or services received from the Claims Administrator or a Network Provider. If a Plan Participant or his Authorized representative wants to register an oral Complaint or file a formal written Grievance about the quality of care or services received from the Claims Administrator or a Network Provider, he should refer to the procedures below.

1. Complaints

A Complaint is an oral expression of dissatisfaction with Us or with Provider services. A quality of service concern addresses appropriateness of care given to a Plan Participant, Our services, access, availability or attitude and those of Our Network Providers.

To make a Complaint, call the Claims Administrator's customer service department at 1-800-392-4089. The Claims Administrator will attempt to resolve the Complaint at the time of the call.

If a Plan Participant or his Authorized Representative is dissatisfied with the Claims Administrator's resolution, he may file a first level Grievance.

2. Grievances

A Grievance is a **written** expression of dissatisfaction with the quality of care or services received from the Claims Administrator or a Network Provider.

To file a first level Grievance, send the first level Grievance to:

Blue Cross and Blue Shield of Louisiana
Claims Administrator
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

The Claims Administrator's customer service department will assist the Plan Participant or his Authorized Representative with filing the first level Grievance, if necessary.

The Claims Administrator will mail a response to the Plan Participant or his Authorized Representative within thirty (30) calendar days from the date the Claims Administrator receives the first level Grievance.

B. INFORMAL RECONSIDERATION: Pre-Service Denial Based on Medical Necessity or Investigational Determinations

In addition to the appeal rights, the Plan Participant's Provider may initiate an Informal Reconsideration to review Utilization Management decisions.

Informal Reconsideration

An Informal Reconsideration is a process to review Utilization Management decisions and is initiated by a request by telephone, made by an authorized Provider to speak to the Claims Administrator's Medical Director or to a peer reviewer. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

An Informal Reconsideration is available only if requested within **ten (10) calendar days** of the date of the initial denial or adverse Concurrent Review determination. The Claims Administrator will conduct the Informal Reconsideration within **one (1) business day** from the receipt of the request. Once the Informal Reconsideration is complete, the Claims Administrator will advise the Plan Participant or his Authorized Representative of the decision and, if necessary, the Plan Participant's additional appeal rights.

C. APPEALS: Standard Appeal, External and Expedited Appeals

A Plan Participant may be dissatisfied with coverage decisions made by the Claims Administrator. For example, rescissions of coverage, denied Authorizations, Investigational determinations, adverse Medical Necessity determinations, Adverse Benefit Determinations based on medical judgment, denied Benefits (in whole or in part), or adverse Utilization Management decisions.

A Plan Participant's appeal rights, including a right to an expedited appeal, are outlined below.

Standard Appeals Process

An Appeal is a **written** expression of dissatisfaction with coverage decisions made by the Claims Administrator. A Plan Participant or his Authorized Representative may file an administrative Appeal or a medical Appeal. The Plan Participant or his Authorized Representative is encouraged to submit written comments, documents, records, and other information relating to adverse coverage decisions.

If the Plan Participant or his Authorized Representative has questions or needs assistance putting an Appeal in writing, or wishes to communicate with the Claims Administrator regarding an Appeal, he may call the Claims Administrator's customer service department at 1-800-392-4089.

MULTIPLE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED, AT ANY LEVEL OF REVIEW.

The appeal process has two (2) mandatory levels of review. At each level of review, the review will involve persons who did not participate in any prior Adverse Benefit Determination and who are not a subordinate to any previous adverse decision-maker. When the Appeal requires medical judgment, the review will involve a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Administrative Appeals

Administrative Appeals involve contractual issues, Rescissions of Coverage, and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or Investigational.

1. First Level Administrative Appeal

If the Plan Participant is not satisfied with the Claims Administrator's decision, a written request must be submitted within **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination for first level administrative Appeals. Request submitted to the Claims Administrator after one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. If the administrative Appeal is denied, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The administrative Appeal decision will be mailed to the Plan Participant, the authorized representative, or Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request: unless the Claims Administrator and Plan Participant mutually agreed that an extension of the time is warranted.

All administrative Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

2. Second Level Administrative Appeal

After review of the Claims Administrator's first level Appeal decision, if the Plan Participant is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of receipt of the first level Appeal decision. Requests submitted after sixty (60) calendar days of receipt of the first level Appeal decision will not be considered.

An Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level Appeals. The Committee's decision is considered final and binding.

The Committee's decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within five (5) days of the Committee meeting.

Send a written request for further review and any additional information to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

3. OGB Voluntary Level Appeal

Not applicable to a rescission of coverage appeal or any appeal requiring medical judgment. These appeals follow the second level external review track for medical Appeals.

The Plan Participant or his Authorized Representative has **thirty (30) calendar days** from receipt of the notice denying the second level administrative Appeal to file an OGB voluntary level Appeal. **To file an OGB voluntary level Appeal,** send the OGB voluntary level Appeal to:

Office of Group Benefits
Administrative Claims Committee
P. O. Box 44036
Baton Rouge, LA 70804

along with copies of all information relevant to the Appeal. The Plan Participant or his Authorized Representative is entitled to receive free of charge, copies of all information relevant to the Appeal from the Claims Administrator (Blue Cross and Blue Shield of Louisiana, Claims Administrator, Appeals and Grievance Unit, P. 0. Box 98045, Baton Rouge, LA 70898-9045).

If the Administrative Claims Committee (ACC) grants the OGB voluntary level Appeal, the Claims Administrator will reprocess the claim. If the ACC denies the OGB voluntary level Appeal, the ACC will notify the Plan Participant or his Authorized Representative, in writing, of the decision within sixty (60) calendar days from the date the ACC received the OGB voluntary level Appeal, or as allowed by law.

Medical Appeals

Medical Appeals involve Adverse Benefit Determinations for Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational and any related prospective or retrospective review determination.

Medical Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana
Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022

1. First Level Internal Medical Appeals

If the Plan Participant is not satisfied with the Claims Administrator's decision, a written request to Appeal must be submitted within **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination for internal medical Appeals. Requests submitted to the Claims Administrator after **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination will not be considered.

A Physician or other healthcare professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, the Claims Administrator will reprocess the Plan Participant's Claim, if any. If the internal medical Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The internal medical Appeal decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request; unless the Claims Administrator and Plan Participant mutually agreed that an extension of the time is warranted.

If the first level Appeal is denied or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative may request a Second Level Appeal (External Review).

2. Second Level Medical / External Appeals

If the Plan Participant still disagrees with the determination on his Claim,, or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative must send their written request for an external Appeal, conducted by a non-affiliated Independent Review Organization (IRO), within **one hundred twenty (120) calendar days** of receipt of the internal Appeal decision, to:

Blue Cross and Blue Shield of Louisiana
Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022

Requests submitted to the Claims Administrator after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered. The Plan Participant is required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. **Appeals submitted by your Provider will not be accepted without this form completed with your signature.**

The Claims Administrator will conduct a preliminary review to determine whether the Plan Participant has a right to an external review within five (5) business days of receiving the request. The Claims Administrator will notify the Plan Participant or his Authorized Representative, in writing, of the decision and requirements for any further action by the Plan Participant or his Authorized Representative within one (1) business day after completing the preliminary review.

If an external review right exists, the Claims Administrator will provide the IRO all pertinent information necessary to conduct external Appeal. The external review will be completed within forty-five (45) days of receipt of the external Appeal request. The IRO will notify the Plan Participant or their authorized representative and all appropriate Providers of its decision.

The IRO decision is considered final and binding.

If you need help or have questions about your Appeal rights, call the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA or 1-866-444-3272.

Expedited Appeals Process

The expedited Appeal process is available for review of the Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize the Plan Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the Plan Participant's treating Physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Expedited Appeals are not provided for review of services previously rendered.

An Expedited Appeal shall be made available to, and may be initiated by the Plan Participant, his authorized representative, or a Provider authorized to act on the Plan Participant's behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

1. Expedited Internal Medical Appeals

   In these cases, We will make a decision no later than seventy-two (72) hours of our receipt of an Expedited Appeal request that meets the criteria for Expedited Internal medical Appeal.

   In any case where the internal Expedited Internal medical Appeals process does not resolve a difference of opinion between the Claims Administrator and the Plan Participant or the Provider acting on behalf of the Plan Participant, the Appeal may be elevated to an Expedited External medical Appeal.

   If an Expedited internal medical Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process and timeframe.

2. Expedited External Medical Appeal

   An Expedited External medical Appeal is a request for immediate review, by an Independent Review Organization (IRO). The request may be simultaneously filed with a request for an internal Expedited medical Appeal, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for Expedited External medical Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

D. Exhaustion

The Plan Participant will have exhausted his administrative remedies under the Plan when the Plan Participant completes any one of the following steps:

- The OGB Eligibility Appeal process;
- Pharmacy Benefit Manager Appeal process;
- The Second Level Expedited Appeal process;

- The Second Level Internal Appeal process;
- The OGB Voluntary Level Appeal process; or,
- The External Review process.

After exhaustion, a claimant may pursue any other legal remedies available to him.

E. Legal Limitations

A Plan Participant must exhaust his administrative remedies before filing a legal action. A lawsuit related to a claim must be filed no later than twelve (12) months after the claim is required to be filed, or more than thirty (30) calendar days after the Plan Participant has exhausted his administrative remedies, whichever is later.

Any and all lawsuits, other than those related to claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

ARTICLE X. CARE WHILE TRAVELING, MAKING POLICY CHANGES AND FILING CLAIMS

The Claims Administrator is continuing to update its online access for Covered Persons. Covered Persons may now be able to perform many of the functions described below, without contacting the Claims Administrator's customer service department. The Claims Administrator invites Covered Persons to log on to **www.bcbsla.com** for access to these services.

All of the forms mentioned in this section can be obtained from the Claims Administrator's regional offices. If the Covered Person needs to submit documentation to the Claims Administrator, the Covered Person may forward it to Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA 70898-9029, or to, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Covered Person has any questions about any of the information in this section, the Covered Person may call the Claims Administrator's customer service department at the telephone number shown on his ID card.

A. How to Obtain Care While Traveling

The Participant's ID card offers convenient access to PPO healthcare outside of Louisiana. If the Covered Person is traveling or residing outside of Louisiana and needs medical attention, please follow these steps:

1. In an Emergency, go directly to the nearest Hospital.
2. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest PPO Network Providers.
3. Use a designated PPO Network Provider to receive the highest level of Benefits.
4. Present the Participant's ID card to the Provider, who will verify coverage and file Claims for the Covered Person.
5. The Covered Person must obtain any required Authorizations from the Claims Administrator.

   NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States (out of country) are covered at the In-Network benefit level. Non-emergency services received outside of the United States (out of country) ARE COVERED AT THE OUT-OF-NETWORK BENEFIT LEVEL.

B. How to File Claims for Benefits

Claims under this Plan will be processed and paid along with the claims of the integrated CDHP. Please refer to the CDHP's plan document for details about how claims are filed under that plan. Covered Persons do not need to file a separate claim to receive reimbursements under this HRA.

C. If Covered Person Has a Question About His Claim

If a Covered Person has a question about the payment of a Claim, the Covered Person can write to the Claims Administrator at the address below or the Covered Person may call the Claims Administrator 's customer service department at the telephone number shown on his ID card or any of the Claims Administrator's local service offices*. If the Covered Person calls for information about a Claim, the Claims Administrator can help the Covered Person better if the Covered Person has the information at hand, particularly the contract number, patient's name and date of service.

Blue Cross and Blue Shield of Louisiana,
5525 Reitz Avenue
P.O. Box 98027
Baton Rouge, LA 70898-9029

Remember, the Covered Person must ALWAYS refer to the his contract number in all correspondence and recheck it against the contract number on his ID card to be sure it is correct.

* Blue Cross and Blue Shield of Louisiana has local service offices located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

ARTICLE XI. RESPONSIBILITIES OF PLAN ADMINISTRATION

A. Plan Administrator Responsibility

The OGB will administer the Plan in accordance with its terms, state and federal law, the OGB's established policies, interpretations, practices, and procedures. The OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding eligibility for benefits and to decide disputes which may arise relative to a Covered Person's rights.

B. Amendments to or Termination of the Plan and/or Contract

OGB has the statutory responsibility of providing Benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and Benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest Benefits for any Participant, whether active or retired, or a Dependent of an Eligible Employee or Retiree.

C. Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to the Covered Persons, and defraying reasonable expenses of administering the Plan. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation.

D. The Claims Administrator is not a Fiduciary

A Claims Administrator is NOT a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

GENERAL PLAN INFORMATION

NAME OF PLAN:

Health Reimbursement Arrangement for
State of Louisiana Employees

PLAN ADMINISTRATOR:

State of Louisiana Office of Group Benefits
Post Office Box 44036
Baton Rouge, Louisiana 70804

(225) 925-6625 or (225) 925-6770 (TDD)
(800) 272-8451 or (800) 259-6771 (TDD)

PLAN NUMBER (PN):

501

TYPE OF PLAN:

Health Reimbursement Arrangement

TYPE OF ADMINISTRATION:

The Plan is a self-funded Group Health Plan. Benefits are administered, on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administrative Services Agreement and the terms and conditions of the Plan.

CLAIMS ADMINISTRATOR:

Blue Cross and Blue Shield of Louisiana (BCBSLA)
5525 Reitz Avenue
Baton Rouge, LA 70809
(800) 392-4089

BCBSLA has been hired to process claims under the Plan. BCBSLA does not serve as an insurer, but merely as a claims processor. Claims for Benefits are sent to BCBSLA. BCBSLA processes and pays claims, then requests reimbursement from Plan. State of Louisiana, Office of Group Benefits is ultimately responsible for providing plan Benefits, and not BCBSLA.

PLAN YEAR ENDS:

December 31

PLAN DETAILS:

The eligibility requirements, termination provisions, Benefits and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any Benefits are described in the Plan.

FUTURE OF THE PLAN:

Although the Plan Administrator expects and intends to continue the Plan indefinitely, the Plan Administrator reserves the right to modify, amend, suspend, or terminate the Plan at any time.

GENERAL NOTICE OF CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under certain circumstances when coverage would otherwise end under any of the Office of Group Benefits-sponsored health plans (hereinafter referred to as "Plan"). **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered by the State of Louisiana (such as life insurance).

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your Spouse and Dependent Children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should get a copy of the Plan Document from the Plan. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Office of Group Benefits, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your Spouse, and your Dependent Children could become qualified beneficiaries and would be entitled to elect COBRA coverage if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted Children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay the entire cost of COBRA coverage.

Who is entitled to elect COBRA Coverage?

If you are an Employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your Spouse. Also, if your Spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce. If you notify the Office of Group Benefits within 60 days after the divorce and can establish that the Employee cancelled the coverage earlier in anticipation of the divorce, the COBRA coverage may be available for the period after the divorce.

A person enrolled as the Employee's Dependent Child will be entitled to elect COBRA coverage, if he or she loses group health coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child."

When is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries only after the Office of Group Benefits has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the Employee, the Participant Employer must notify the Office of Group Benefits of the qualifying event within 30 days following the date coverage ends.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the Employee and Spouse, or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Office of Group Benefits in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You must follow the notice procedures specified by the Office of Group Benefits. If notice is not provided to the Office of Group Benefits during the 60-day notice period, ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

Once the Office of Group Benefits receives timely notice of the qualifying event, it will forward the information to its third-party COBRA Administrator, who will notify You of your right to elect COBRA coverage.

Electing COBRA

Once the Office of Group Benefits receives timely notice that a qualifying event has occurred, each qualified beneficiary will have an independent right to elect COBRA coverage. Once the Office of Group Benefits receives timely notice of the qualifying event, it will forward the information to its third-party COBRA Administrator, who will notify you of your right to elect COBRA coverage. Covered Employees and Spouses (if the Spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their Children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the covered Employee's divorce, or a Dependent Child's losing eligibility as a Dependent Child, COBRA coverage can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage under the Plan for his Spouse and Children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months

after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction in hours.

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Extension of COBRA Coverage

The COBRA coverage periods described above are maximum coverage periods. There are two ways in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration (or by the staff of the COBRA Administrator in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment) to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered Employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first (61st) day after the Covered Employee's termination of employment or reductions of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).
For persons eligible to receive Social Security disability benefits, the disability extension is available only if you notify the Office of Group Benefits and the COBRA Administrator in writing and submit a copy of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", the disability extension is available only if you submit to the COBRA Administrator in writing proof of total disability before the initial 18-month COBRA coverage period ends.

You must also provide this notice to the COBRA Administrator within 18 months after the covered Employee's termination of employment or reduction in hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" (you may obtain a copy of this form from the COBRA Administrator at no charge, or you can download the form at **www.discoverybenefits.com**), **and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period and within 18 months after the Employee's termination of employment or reduction of hours, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving 18 months of COBRA coverage because of the covered Employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the Spouse and Dependent Children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the Spouse and any Dependent Children receiving COBRA coverage if the Employee or former Employee dies, or gets divorced, or if the Dependent Child stops being eligible under the Plan as a

Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered Employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of:

- the date of the second qualifying event; and
- the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still an Employee covered under the Plan).

In providing this notice, you must use the COBRA Administrator's form, entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from the COBRA Administrator at no charge, or you can download the form at **www.discoverybenefits.com**), **and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator within the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered Employee during COBRA coverage period

A Child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The Child's COBRA coverage begins on the Child's date of birth, date of adoption, or date of placement for adoption if the Child is enrolled in the Plan through the HIPAA Special Enrollment process designated by OGB, or on the first day of the following Plan year if the Child is enrolled through Annual Enrollment. The COBRA coverage lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A Child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Office of Group Benefits during the covered Employee's period of employment with the Participant Employer is entitled to the same rights to elect COBRA as an eligible Dependent Child of the covered Employee.

Health Insurance Marketplace

There may be other coverage options for you and your family. Through the Affordable Care Act, you are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and Out-of-Pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity with another group health plan for which you are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you must keep the Office of Group Benefits and the COBRA Administrator informed of any changes in your address and the addresses of your covered family members. You should also keep a copy, for your records, of any notices you send to the Office of Group Benefits and/or the COBRA Administrator.

Plan Contact Information

You may obtain information about the Plan and COBRA coverage on request from:

Plan Information:	**Office of Group Benefits** **Eligibility Department** **Post Office Box 44036** **Baton Rouge, Louisiana 70804** **1.800.272.8451** **225.342.9917 FAX**
COBRA Information:	Discovery Benefits, Inc. P.O. Box 2079 Omaha, NE 68103-2079 1.866.451.3399

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this notice, and you may obtain copies from the COBRA Administrator without charge or download them at **www.discoverybenefits.com**). Oral notice, including notice by telephone, is not acceptable. Electronic e-mailed notices are not acceptable.

How, When, and Where to Send Notices: You must mail or FAX your notice to:

Discovery Benefits, Inc.
P.O. Box 2079
Omaha, NE 68103-2079
1.855.678.1733 (Fax)

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If Faxed, your notice must be received by the Eligibility department at the number specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of COBRA coverage," and "Second qualifying event extension of COBRA coverage.")

Information Required for All Notices: Any notice you provide must include: (1) the name of the Plan; (2) the name and address of the Employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Notice Procedures (continued)

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce, your notice must include a copy of the decree of divorce. If your coverage is reduced or eliminated and later a divorce occurs, and if you are notifying the Office of Group Benefits that your Plan coverage was reduced or eliminated in anticipation of the divorce, your notice must include evidence satisfactory to the Office of Group Benefits that your coverage was reduced or eliminated in anticipation of the divorce.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination, if applicable; (5) a copy of the Social Security Administration's determination, if applicable; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled. For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", any notice of disability must also include proof of total disability, such as medical evidence presented by the applicant's physicians and the applicant's work history.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce, a copy of the decree of divorce.

Who May Provide Notices: The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Louisiana

Section III

Notices and Forms

Louisiana HMO Louisiana SOUTHERN NATIONAL LIFE INSURANCE COMPANY, INC.

SUMMARY OF PRIVACY PRACTICES NOTICE

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc., believe that privacy and confidentiality regarding personal medical information is important to every customer. And securely protecting our customers' privacy is a responsibility we take very seriously.

We want you to know there is a federal regulation that governs the privacy of your medical information and how we use and share that information in the course of our regular business activities. This federal regulation requires us to provide you with a detailed description – or "Notice"– of how we use your medical information.

The attached Notice goes into detail on how we may use and share your medical information in the course of treatment, payment and health care (business) operations. In general, unless it is described in the accompanying Notice, we will not use or disclose your medical information without your written authorization. For example, we may use and disclose your medical information to:

- Enroll you in our plan
- Determine your eligibility for benefits
- Pay your claims
- Underwrite your contract/certificate of coverage
- Share data with your Quality Blue doctor
- Give your healthcare providers updates that help them treat you
- Connect you with Blue Cross health coaches
- Audit our business practices
- Conduct medical reviews
- Conduct quality improvement activities
- Bill you or your employer for your premiums
- Develop strategic business plans
- Remind you about important screenings, shots or tests
- Participate in research, if appropriate regulations are followed
- Improve our services

Your information may be shared with the physicians or other providers who treat you, with other insurance companies, with your employer (following specific guidelines), or with a company we hire to help us do our work. We may also disclose your medical information to your family members, friends and others you choose to involve in your health care or in the payment of your health care.

Although this occurs rarely, we may also use and disclose your medical information when required by law for various public interest activities, including regulatory oversight of our company (by the Department of Insurance, for example), law enforcement, disaster relief, and certain other public benefit functions.

The federal privacy rules also give you certain rights. Please review this entire Notice to learn about your rights and how to put them to use for you, as well as the procedure to voice complaints regarding our privacy practices.

Maintaining your trust and confidence is our highest priority, and we value your business. Thank you for being our customer.

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BLUE CROSS AND BLUE SHIELD OF LOUISIANA & HMO LOUISIANA, INC.
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect September 23, 2013, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and send the new Notice to our health plan subscribers at the time of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

Uses and Disclosures of Medical Information

We will refer to your "health information" throughout this Notice. When we say "health information," we mean what the federal privacy rules ("the HIPAA privacy regulations") call "Protected Health Information." This is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; (iii) the past, present, or future payment for the provision of health care to you. Any terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Regulations as set out in 45 C.F.R. § 164.501.

REQUIRED DISCLOSURES OF YOUR HEALTH INFORMATION

We **must** disclose your health information:

- To you or someone who has the legal right to act for you (your personal representative), if the information you seek is contained in a designated record set, and
- The Secretary of the Department of Health and Human Services, if necessary, to investigate or determine our compliance with the HIPAA Privacy Regulations.

PERMISSIVE DISCLOSURES OF YOUR HEALTH INFORMATION

We **have the right** to use and disclose your health information for:

Treatment: We may disclose your health information to a physician or other health care provider to treat you. For example, we may send a copy of a member's medical records we maintain to a physician who needs the additional information to treat the member.

Payment: We may use and disclose your health information to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits, and the like. We may disclose your health information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your health information for health care operations. Health care operations include:

- reviewing and evaluating health care provider and health plan performance, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- health care quality assessment and improvement activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage (although we are prohibited from using or disclosing any genetic information for these underwriting purposes); and
- business planning, development, management, and general administration, including customer service, grievance resolution, de-identifying health information, and creating limited data sets for health care operations, public health activities, and research;
- Sharing detailed medical claims and wellness information with your primary care physician to improve care and reduce costs.

For a full list of the activities covered by the terms in this section please consult the definitions set out in 45 C.F.R. § 164.501.

Others Covered by the Privacy Rule: We may disclose your health information to another health plan or to a health care provider for certain health care operations subject to federal privacy protection laws. We may do so as long as the plan or provider has or had a relationship with you and the health information is for that plan's or provider's health care quality assessment and improvement activities, evaluation, or fraud and abuse detection and prevention.
For example, we may share your information with your doctors for their licensing or credentialing activities.

Business Associates: We hire individuals and companies to perform various functions on our behalf or to provide certain types of services for us. In order to help us, these business associates may receive, create, maintain, use, or disclose your health information. Before they may have any contact with your health information, we require them to sign a written agreement stating they will keep your health information private and secure.

Examples of our business associates include:

- Medical experts hired to review claims;
- A pharmacy benefits management company hired to assist us in managing pharmacy claims;
- A company hired to conduct data analysis to help us determine which of our programs and services are most helpful to customers, which should be changed and others that we should start.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, we will not be able to undo any action that was taken before that authorization was revoked. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in this Notice. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of health information for marketing purposes, and disclosures that constitute a sale of protected health information require your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: Unless you object, we may disclose your health information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the health information that is related to the person's involvement.
We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as medical emergency or during disaster relief efforts (for example, to Red Cross during a natural disaster).

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your health information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether or not you are enrolled in a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is information about claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although this summary health information does not specifically identify any individual, it still may be possible to identify you or others through review of this summary health information.
We may disclose your health information and the health information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must meet certain requirements. This includes amending the plan document for your group health plan to establish the limited uses and disclosures it may make of your health information. Please see your group health plan document for a full explanation of the limitations placed on your employer for the use of this information and for any disclosures that may be made to the group health plan itself.

Health-Related Products and Services: Where permitted by law, we may use your health information to communicate with you about health-related products, benefits and services and payment for those products, benefits and services that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan. For example, we may contact you about a Medicare Supplemental policy when you near age 65.

Public Health and Benefit Activities: Although this does not occur often, we may use and disclose your health information when required by law and when authorized by law for the following kinds of public interest activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- for research in certain situations, such as when:
  (1) an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information and approved the research or
  (2) conducting research with de-identified or limited data sets to learn more about how to help members improve their health;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Individual Rights

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please submit your request in writing, sign your request, and mail it to the Blue Cross and Blue Shield of Louisiana Privacy Office at P.O. Box 84656, Baton Rouge, LA 70884-4656. Our contact information is provided at the end of this Notice.

Access: You have the right to examine and to receive a copy of your health information we maintain about you in a "designated record set," with limited exceptions. This may include an electronic copy in certain circumstances if you make this request in writing.

Generally, a "designated record set" contains:

- claims and payment information;
- enrollment and billing information;
- other records used to make decisions about your health care benefits.

We may charge you reasonable, cost-based fees for a copy of your health information, for mailing the copy to you, and for preparing any summary or explanation of your health information you may request. Contact us using the information at the end of this Notice for information about our fees. You may withdraw your request if you do not wish to pay the fees.

In certain situations we may deny your request to inspect and obtain a copy of your health information. If we deny your request, we will notify you in writing and will inform you whether or not you have the right to have the denial reviewed.

Disclosure Accounting: You have the right to an accounting of certain disclosures that we make of your health information, excluding disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this Notice for information about our fees.

Amendment: You have the right to request that we amend your health information that we maintain about you in your designated record set. We may deny your request for certain reasons. For example, we may deny your request if the information you want to amend was created by your doctor. If we deny your request, we will provide you a written explanation, and explain to you how you can disagree with the denial by filing a statement of disagreement with us. If we accept your request, we will make your amendment part of your designated record set, and use reasonable efforts to inform others of the amendment who we know may have relied on the unamended information to your detriment, as well as persons you tell us you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your health information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will honor our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing and agreed to by our Privacy Office.

Confidential Communication: If you believe that a disclosure of all or part of your health information may endanger you if sent to your current mailing address, you have the right to request that we communicate with you in confidence about your health information by a different means or to a different location that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.
We will accommodate your request if it is reasonable. You must specify the alternative means of contact or location for confidential communication, and continue to permit us to collect premiums and pay claims under your health plan. Please note that other information that we send to the subscriber about health care benefits received may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence. If you have given someone else permission to receive health information about you, a request for confidential communications will cancel this permission unless you tell us otherwise.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you have the right to receive this Notice in written form. Please contact us using the information at the end of this Notice to obtain this Notice in written form.

Potential Impact of State Privacy Laws: The federal health care Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, or disclosure of health information of minors.

Breach Notification: In the event of a breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your health information, you may complain to us using the contact information at the end of this Notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, Region VI, 1301 Young Street, Suite 1169, Dallas, TX 75202. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

By mail:
Privacy Office
Blue Cross and Blue Shield of Louisiana
P.O. Box 84656
Baton Rouge, LA 70884-4656

Telephone: (225) 298-1751
Fax: (225) 298-1590

E-mail: Privacy.Office@BCBSLA.com
(Individual Rights requests will not be accepted via e-mail.)

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

TO: All OGB Health Plan Members

SUBJECT: Notice of Privacy Practices

The Office of Group Benefits (OGB), the State of Louisiana group health plan administrator, wants you to know that we understand and appreciate the sensitive nature of information entrusted to us in connection with the administration of your health plan. This includes identifying information that we have created or received about you or about your past, present, or future health and/or medical condition(s), medical care provided to you, or information related to payment for medical services you have received.

OGB is committed to safeguarding the privacy of the health information of our members and their dependents that is protected under federal and state laws. This is not only a legal requirement, but an important ethical obligation imposed upon every member of the OGB workforce as well as contractors who provide services for or on behalf of OGB. Everyone who creates, collects, stores, processes, or works with your health information for the OGB is committed to ensuring its confidentiality and security.

This Notice tells you about the ways that we may collect, use, and disclose your protected health information and about your rights concerning your protected health information. Please review it carefully.

Sincerely,

David W. Couvillon
Chief Executive Officer

An Equal Opportunity Employer

STATE OF LOUISIANA

OFFICE OF GROUP BENEFITS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

The Office of Group Benefits (OGB)[1] is committed to safeguarding the privacy of our members' and their dependents' health information that is protected under federal and state laws. This information includes identifying data about you[2] that we have created or received about your past, present, or future health and/or medical condition(s), medical care provided to you, or information related to payment for medical services you have received.

This Notice tells you about the ways that we may collect, use, and disclose your protected health information and about your rights concerning your protected health information.

We are required by federal law[3] to maintain the privacy of protected health information, to advise you of any breach that may have compromised the privacy or security of your protected health information, and to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect.

GENERAL WAYS WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT AN AUTHORIZATION

Under federal law, health care providers and health plans may use and disclose your protected health information without your authorization for three general purposes: treatment, payment, and health care operations. As a health plan, we principally use and disclose your protected health information without your authorization for payment and health care operations.[4] The examples below illustrate the types of uses and disclosures we may make without your authorization for these purposes.

Payment: We use and disclose your protected health information in connection with payment for your covered health expenses under an OGB plan. For example, we may use or disclose your protected health information to process claims or to be reimbursed by another insurer that may be responsible for payment of your claims.

[1] Throughout this Notice, the 0ffice of Group Benefits is referred to as "we" or "us".

[2] For simplification purposes, the terms "you" and "your" refer to both the 0GB health plan member and his/her enrolled dependents. Except where stated otherwise, the rights specified in this Notice apply to both the member and his/her dependents.

[3] The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

[4] However, Louisiana law prohibits us from disclosing results of genetic tests for any purpose without your authorization or a Court order.

We may also issue Explanations of Benefits (EOBs) to members so that they can monitor the payments made for

their own care and for the care of their dependents.

Health Care Operations: We use and disclose your protected health information to perform our plan activities, such as administration, quality and performance assessment, case management, care coordination, claims administration, customer service, billing, and collection. This would include disclosure of protected health information to our third-party administrators and other business associates who assist us with certain aspects of plan administration. In some cases, we may use or disclose information for purposes of underwriting or determining premiums (note that protected health information that consists of genetic information will never be used for underwriting purposes). We will obtain assurances from our business associates that they will appropriately safeguard your protected health information.

OTHER USES AND DISCLOSURES WITHOUT AN AUTHORIZATION

- **As Required by Law:** We must disclose protected health information when required to do so by law. For example, we must disclose information specified by the Secretary of Health and Human Services for determining our compliance with federal privacy regulations and to government benefits programs, such as Medicare and Medicaid, in order to review your eligibility and enrollment in these programs.

- **Public Health Activities**: We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability, or for tracking events such as births and deaths.

- **Victims of Abuse, Neglect or Domestic Violence**: We may disclose protected health information to government authorities about abuse, neglect, or domestic violence.

- **Health Oversight Activities**: We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.

- **Judicial and Administrative Proceedings**: We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information in certain cases in response to a subpoena, discovery request, or other lawful purpose as long as HIPAA's administrative requirements are met.

- **Law Enforcement**: We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process, to identify or locate a suspect, or to provide information about the victim of a crime.

- **Coroners, Funeral Directors, Organ Donations**: We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donations.

- **To Avert a Serious Threat to Health or Safety**: We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

- **Special Government Functions:** We may disclose protected health information as required by military authorities or to authorized federal officials for national security and intelligence activities.

- **Workers' Compensation Programs:** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

- **To Your Personal Representatives:** With certain exceptions, if a person has legal authority to make health care decisions for you, we will consider that person to be your personal representative and treat him or her as you for purposes of determining your privacy rights. This would include disclosing your protected health information to your personal representative upon his or her request.

- **To Persons Involved with Payment for Your Care**: We may disclose to a family member, other relative, or your close personal friend (or any other person identified by you), personal health information directly relevant to that person's involvement with payment related to your health care. With the exception of E0Bs provided to members, we can only do so if you are present and do not object or, if you are not present, when we use our professional judgment to determine that the disclosure is in your interest.

- **For Plan-Related Communications:** We may use and disclose our knowledge about you to provide to your information about benefits available to you under your current coverage and about our other health care plans and benefits that may be of interest to you.

- **For Research**: We may use and disclose your protected health information for research purposes without an authorization, if specific requirements are met.

OTHER USES OR DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Uses and disclosures of your protected health information not mentioned above will be made only with your written authorization, unless otherwise permitted or required by law. If we ask for your authorization, we must provide you with a copy of the authorization after you have signed it.

You may revoke an authorization at any time by delivering to us a written notice of revocation, except to the extent that we have already taken action in reliance on the authorization or if we are permitted by law to use the information to contest a claim or coverage under your health plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that we maintain about you.

- **Right to Access Your Protected Health Information:** You have the right to review and/or obtain copies from us of your protected health information records, with some limited exceptions. The records that we maintain usually include enrollment, billing, claims payment, and case or medical management records. We may charge a fee for the cost of producing, copying, and mailing your requested information but, if we do, we will tell you the cost in advance.
- **Right to Access Electronic Records:** You may request access to electronic copies of electronic health records or your PHI contained in the Designated Record Set or an electronic health record, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic PHI will be provided in a mutually agreed format, and you may be charged for

the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

- **Right to Amend Your Protected Health Information.** If you feel that any protected health information we maintain about you is incorrect or incomplete, you may request that we amend the information. If the request is for amendment of other than basic demographic information, your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that we did not create or if you ask us to amend a record that we believe is already accurate and complete.

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision, and we have the right to rebut the statement.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include disclosures related to payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. The time period may not be longer than six years. Your request should indicate the format in which you want the accounting (for example, on paper or electronically). The first accounting that you request within a 12- month period will be free. For additional accountings within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and/or Disclosure of Your Protected Health Information:** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment, or health care operations. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us the following: what information you want to limit; whether you want to limit how we use or disclose your information or both; and to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications:** You have the right to request that we use a certain method of communicating with you (for example, by telephone only) or that we send confidential information only to a certain location (for example, only to your office). Your request to receive confidential communications must be reasonable, must be in writing, and must specify how or where you wish to be contacted. We will make every reasonable attempt to accommodate all reasonable requests and must accommodate that request if you state in writing that communication through normal processes could endanger you in some way.
- **Right to a Paper Copy of This Notice:** You have a right at any time to request and receive a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

Contact Information for Exercising Your Rights - You may initiate the exercise of any of the rights described above by contacting us as follows:

HIPAA Compliance Director
Louisiana 0ffice of Group Benefits
P.0. Box 44036
Baton Rouge, LA 70804-4036
Phone: 225.342.9489
Facsimile: 225.342.9968
Email: hipaa-ogb@la.gov

ADDITIONAL PROTECTIONS FOR YOUR HEALTH INFORMATION

OGB requires all employees to follow policies and procedures that limit access to protected health information about members and their dependents to those employees and other persons who need it to perform their job responsibilities. With only a few exceptions (such as disclosures to you and made with your authorization), we also make reasonable efforts to limit the amount of protected health information that we use, disclose, and request to the minimum necessary to accomplish the intended purpose. In addition, the 0GB maintains physical, administrative, and technical security measures to safeguard your protected health information.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time, effective for all protected health information that we already have about you as well as such information that we receive in the future. We also post a copy of our current Notice on our website at info.groupbenefits.org and distribute the new notice or information about the update as required by the applicable regulations.

We will not implement any changes in the privacy practices described in this Notice prior to the effective date of the revised Notice.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints must be in writing.

Any complaint to the 0GB must be made in writing (either on paper or electronically) and be sent to the following:

HIPAA Compliance Director
Louisiana Office of Group
Benefits P. O. Box 44036
Baton Rouge, LA 70804-4036
Phone: 225.342.9489
Facsimile:225.342.9968
Email:hipaa-ogb@la.gov

Complaints to the Secretary must be in writing (either on paper or electronically) and should be filed within 180 days of when you knew (or should have known) that a violation had been committed. (The Secretary may waive the time limit for good cause.) In the complaint, you must name the organization you feel has violated your rights and describe the violation. You may contact the Secretary asfollows:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Email to OCRComplaint@hhs.gov
Toll Free: 1.800.368.1019
Facsimile: 1.202.619.3818
Website: https://www.hhs.gov/hipaa/filing-a-complaint/index.html

We will not retaliate against you or penalize you in any way for filing a complaint or for exercising any of your other rights as specified in this Notice.

FOR FURTHER INFORMATION

If you have any questions about the matters covered in this Notice, you may contact us as follows:

HIPAA Compliance Director
Louisiana 0ffice of Group Benefits
P. 0. Box 44036
Baton Rouge, LA 70804-4036
Phone : 225.342.9489
Email: hipaa-ogb@la.gov

This notice is effective as of January 1, 2021.

Louisiana HMO Louisiana

WOMEN'S HEALTH AND CANCER RIGHTS ACT
ENROLLMENT NOTICE FOR ALL COVERED MEMBERS

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 benefits in connection with a mastectomy resulting from breast cancer and elects breast reconstruction, coverage will be provided for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to contralateral prophylactic mastectomy, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future;
- prostheses; and
- treatment of physical complications of all stages of the mastectomy, including lymphedema.

Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. You are eligible for these screenings if You:

- were previously diagnosed with breast cancer;
- completed treatment for breast cancer;
- underwent bilateral mastectomy; and
- were subsequently determined to be clear of cancer.

These benefits will be provided in a manner determined in consultation with the attending physician and the patient, and subject to the same deductibles, coinsurance, and copayments (if any) applicable to other medical and surgical benefits provided under this plan. Information on the plan's specific deductible, coinsurance, or copayment amounts is found in the Schedule of Benefits document that is issued with your health benefit booklet.

If you have questions about this notice or about the coverage described herein, please contact our Customer Service Department at the number listed on the back of your ID card.

40XX0941 R01/21

Louisiana

OTHER COVERAGE QUESTIONNAIRE FOR OGB HEALTH PLANS

Post Office Box 98027
Baton Rouge, Louisiana 70898-9917

Customer Service: 1-800-392-4089 Fax: 1-225-298-7772

RESPONSE REQUIRED

This information is required to complete the processing of any claims submitted. Failure to return this questionnaire will cause a delay in processing. Please fill out this questionnaire and return it to us within ten (10) days regardless if you have other health care coverage or not. A return envelope has been provided, as well as toll-free customer service phone numbers and facsimile numbers. Thank you for your prompt response.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Member ID Number: _____

Group Number: ST222ERC

In addition to your Blue Cross and Blue Shield of Louisiana plan coverage, are/were you, your spouse, or dependent children covered by another group health insurance plan (do not list Medicare)., including any other Blue Cross and Blue Shield coverage?

☐ NO: Signature _____ ☐ YES: Please provide the following applicable information.

SECTION A – OTHER INSURANCE

Are you or any other dependent covered by another medical insurance policy?

❑ No If No, please complete section C, sign, date and return this questionnaire to us, including "No other insurance."

❑ Yes If Yes, please complete all of the fields below that pertain to the member(s) that has the other coverage

Other Insurance Carrier's Name				Policy ID Number
Address				
City	State	Zip		Phone Number

NAME(S) OF DEPENDENTS ON POLICY

Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number

Policyholder's Name	Date of Birth
Original Effective Date of Other Insurance	If Cancelled, Cancellation Date

Is the policyholder:

❑ Actively working for the group ❑ Inactive

❑ Retired, retirement date: _____ ❑ On COBRA, which began :_____

Member's Employer			
Address			
City	State	Zip	Phone Number

-SEE OTHER SIDE-

SECTION B – COURT ORDER INFORMATION If this does not apply, skip to Section C	
Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)? ❑ Yes ❑ No	
List the name(s) of the dependent(s) that this applies to	
If yes, who is the person(s) listed to maintain health coverage?	
What is the relation to the children?	Who has custody of the child(ren) more than 50% of the time?
Documentation of the court order may be requested from your Health Plan Administrator.	

SECTION C	
I HEREBY CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE TRUE, CORRECT AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND BELIEF.	
INSURED'S SIGNATURE	INSURED'S SOCIAL SECURITY NUMBER
DATE	SPOUSE'S NAME
INSURED'S DAYTIME TELEPHONE NUMBER	SPOUSE'S SOCIAL SECURITY NUMBER

Louisiana

AUTHORIZED DELEGATE FORM
FOR OGB HEALTH PLANS

AUTHORIZED DELEGATE FORM

Instructions: This form is used for you to give Blue Cross and Blue Shield of Louisiana (BCBSLA)** permission to share your protected health information with another person or company (for example, with your spouse or insurance agent). Please fill out Section C with your information and Section D, with the information on the person or company who is to get the information. You must also sign the form in Section F.

**BCBSLA refers to Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana and its subsidiary HMO Louisiana, Inc. (collectively referred to herein as "BCBSLA")

Section A. Purpose

This form is submitted at the request of the person listed in Section C to allow BCBSLA to share that person's protected health information with those listed in Section D.

Section B: Protected Health Information to be disclosed

I give BCBSLA permission to disclose any of my personal information protected by federal or state law to the person(s) or company listed in Section D. I understand that this personal information may contain detailed medical information, except for psychotherapy notes, HIV information, or genetic information. (An additional authorization form is required to release those types of information).

Section C: Member Information (required)

(List the specific person whose information is to be shared, even if that person is not the policy holder.)

*Name: _____

*Address: _____

*City: _____ State: _____ Zip: _____

*Member ID Number: _____ OR Social Security Number: _____

Section D: Person(s) or Organization(s) to Receive Information (required)

Name the person or company to whom BCBSLA may give your protected information. We must confirm the identity of the person(s) when they call, so please provide the date of birth or driver's license number of the person or the tax ID number of the company you list below.

Person / Organization #1	Person / Organization #2
*Name_____	*Name_____
*Address_____	*Address_____
*City_____State____Zip_____	*City_____State____Zip_____
*Date of Birth / Tax ID:_____	*Date of Birth / Tax ID:_____
*Driver's License #: _____	*Driver's License #: _____

*This information is required to process the form.

(Over)

Section E: Important Information

No Conditions. BCBSLA will continue providing you with services if you do not complete this form. We will just not be able to share your information with the people you list unless this form is completed.
Further disclosure. If person(s) or company listed in Section D is not required to follow the federal health information privacy laws, they may further share your information and it may no longer be protected by the federal health information privacy laws.
Expiration. This authorization will automatically expire upon BCBSLA's knowledge that you have ended your health insurance coverage.
Right to Revoke. You may withdraw your permission to allow BCBSLA to share your information with those listed on this form by writing to the Privacy Office. Withdrawing your permission will not affect any action taken before we received your letter.

Section F: Member Signature (required)

I, _____, have read and thought about the contents of this form. I agree that the information I put on this form is correct. I understand that by signing this form I am giving permission to BCBSLA to share my protected health information with those listed in Section D.

Signature:_____ Date:_____

If this form is signed by someone <u>other</u> than the member, please complete Section G.

Section G: Legal Representative

If this authorization is signed by a legal representative * or someone other than the member on behalf of the person listed in Section C, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

NOTE: You MUST attach legal documentation of guardianship or Power of Attorney. This documentation is required to process the authorization form.

* Legal representative is a legal designation and generally refers to the parent of a minor, legal guardian, or holder of Power of Attorney.

Privacy Office
5525 Reitz Avenue, Baton Rouge, LA 70809-3802
Phone: (225) 298-1751

Send Completed Forms to:

BLUE CROSS CUSTOMER SERVICE
BLUE CROSS AND BLUE SHIELD OF LOUISIANA
P.O. BOX 98027
BATON ROUGE, LA 70898-9917
FAX (225) 298-7772

Louisiana HMO Louisiana

Important Note about Balance Billing

Why are we sending this notice?

Blue Cross and Blue Shield of Louisiana is required by law to send the notice below to all members when they enroll and every year after that they are a member. Please carefully read this notice.

BALANCE BILLING DISCLOSURE 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, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT WWW.BCBSLA.COM OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN 1-800-392-4089.

Confused?

It's okay! Healthcare can be complicated. We try to make it as simple as we can, but we know that sometimes simplicity isn't possible. This is one of those cases. We'll try to answer some of your questions below.

What does this mean for you?

You probably know that to get the most out of your insurance, you should see a doctor or go to a hospital that is in your network. This means that we have contracted with those doctors, and they've agreed to accept certain prices for the care they give. They have also agreed to file claims for you and accept our payment for those claims, together with the cost sharing amounts (deductible, coinsurance or copayment) that you pay under your plan, as full payment for those services. They have agreed not to collect any additional amounts from you.

What is balance billing?

Doctors or hospitals that are out of your network do not have a contract with us. So they have not agreed to accept our payment plus your cost share (deductible, coinsurance or copayment) as full payment of those services. They will take those payments, but still may bill you for their full charges as well. This is called balance billing.

What is a hospital- or facility-based physician?

Hospital-based doctors are anesthesiologists, emergency room doctors, neonatologists, pathologists, radiologists and similar types of doctors. Even though a hospital is in your network, doctors like these who care for you at the hospital may not be. If they are not in your network, they can balance bill you. You can find out what doctors are in network at hospitals near you at www.bcbsla.com/hbp; choose the list for your area.

What about emergencies?
In the case of a true emergency, get help at the nearest emergency room regardless of network. Check your plan booklet for what an "emergency medical condition" means. If it's not a true emergency, your doctor or an urgent care center may be able to help you.

What can you do?
If you expect to go to the hospital for care, please take a moment to look at the list of hospital-based doctors. You can find this list at www.bcbsla.com/hbp or call us. And, when a hospital-based doctor group leaves your network, we will send you a letter and update this list.

- If the hospital uses doctors who are not in your network, you can ask to have your care moved to a hospital that does have network doctors. We know this isn't ideal, but it's your best bet to avoid balance billing later.
- We know you can't always plan when you go to the hospital or have time to check this list. If it's a true emergency, don't worry about your network.

What happens if you see a hospital-based doctor out of network?
We know you don't always have a choice in hospital doctors. If you do wind up seeing a doctor out of your network, we try to make the process as simple for you as we can. But it's important to remember, there is always a risk of balance billing when you see any doctor who does not have an agreement with us.

- We will pay the doctor as much as your plan allows and at least what the law requires for covered care.
- You will still have to pay your cost share, if you have one.
- The doctor could balance bill you for more. If you do get a bill, you can ask the doctor to take what we paid as payment in full, but the doctor does not have to do so.
- If you go to other providers out of your network, you may have to file your own claim and we will pay you based on your plan. Then, you will have pay for your care.

Finding what providers are in network:
You can search for all providers in your network by going to www.bcbsla.com/ogb and click on Louisiana Provider Directory or National Provider Directory.

What about emergencies?
In the case of a true emergency, get help at the nearest emergency room regardless of network. Check your plan booklet for what an "emergency medical condition" means. If it's not a true emergency, your doctor or an urgent care center may be able to help you.

Questions?
Please call Customer Service at 1-800-392-4089.

Thank you for being our customer. If you still have questions, please call us or visit www.bcbsla.com/ogb.

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

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 313 BATON ROUGE, LA

POSTAGE WILL BE PAID BY ADDRESSEE

Louisiana

Attn: OGB Customer Service
PO Box 98027
Baton Rouge LA 70898-9917

INSIDE TINT REQUIRED

04EN0148 R01/16


Louisiana


OFFICE OF GROUP BENEFITS
ogb
LOUISIANA