2014 ANNUAL ENROLLMENT GUIDE

PPO, HMO and Consumer Driven Health Plan with HSA for State of Louisiana Employees and Retirees Administered by Blue Cross and Blue Shield of Louisiana

CUSTOMER SERVICE LINE 1.800.392.4089 · WWW.BCBSLA.COM/OGB
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*This Annual Enrollment Guide is presented for general information only. It is not a benefit plan, nor intended to be construed as the Blue Cross benefit plan document. If there is any discrepancy between this Annual Enrollment Guide and the Blue Cross benefit plan document and Schedule of Benefits, the FINAL Blue Cross benefit plan document and Schedule of Benefits will govern the benefits and plan payments.*
Blue Cross and Blue Shield of Louisiana is proud to serve your healthcare needs. Your Blue Cross plan offers many benefits and features, including:

- a large network of doctors and hospitals
- physician office visits
- direct access to specialty care without a referral
- member discounts and savings through Blue365®
- preventive and wellness services
- online tools to help you get the most from your health plan
- an ID card recognized around the world
- local customer service

Service...

Blue Cross is committed to meeting the challenging demands of healthcare in the 21st century. As part of this commitment, we constantly strive for excellence in customer service. Our goal is to continuously bring Blue Cross plan members the high level of service they expect and deserve. Survey results from polling the state of Louisiana employees and retirees reveal that more than 75 percent of those members were highly satisfied overall with their Blue Cross experience, and more than 85 percent were highly likely to choose us again.

Your Health. Our Commitment.

Ready to Enroll?

- Active employees can go to their agency’s HR Department to complete a GB-01 form.
- Retirees can go to their former agency’s HR Department. Retirees can also enroll by sending a letter to OGB stating that they wish to enroll. Retirees should be sure to include their name, Social Security number and daytime phone number with the area code. The letter must be signed by the retiree, dated and mailed to the following address:

  Office of Group Benefits | Eligibility Dept. | P.O. Box 66678 | Baton Rouge, LA 70896

CUSTOMER SERVICE

- online: [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb)
- by phone: 1.800.392.4089
- by email: ogbhelp@bcbsla.com

To view the Summary of Benefits and Coverage (SBC), go to [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb).
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PPO
Preferred Provider Organizations
**SCHEDULE OF BENEFITS**

Lifetime Maximum Benefit: .......................................................................................................................... Unlimited

Benefit Period: .............................................................................................................................................. 01/01/14 – 12/31/14

Deductible Amount per Benefit Period:

**Individual:**

Active Employees and Dependents: ........................................................................................................... $500.00
Retirees (With and Without Medicare): ........................................................................................................ $300.00

Family Unit Maximum: ................................................................................................................................. 3 Individual Deductibles

Maximum Out-of-Pocket per Benefit Period:

<table>
<thead>
<tr>
<th>Family Unit Maximum:</th>
<th>Includes all eligible Copayments, Coinsurance Amounts and Deductibles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Active Employee</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$1,500</td>
</tr>
<tr>
<td>Employee Plus One</td>
<td>$3,000</td>
</tr>
<tr>
<td>(Spouse or Child)</td>
<td></td>
</tr>
<tr>
<td>Family of 3</td>
<td>$4,500</td>
</tr>
<tr>
<td>Family of 4</td>
<td>$5,500</td>
</tr>
<tr>
<td>Family of 5</td>
<td>$6,500</td>
</tr>
<tr>
<td>Family of 6</td>
<td>$7,500</td>
</tr>
<tr>
<td>Family of 7</td>
<td>$8,500</td>
</tr>
<tr>
<td>Family of 8</td>
<td>$9,500</td>
</tr>
<tr>
<td>Family of 9</td>
<td>$10,500</td>
</tr>
<tr>
<td>Family of 10</td>
<td>$11,500</td>
</tr>
<tr>
<td>Family of 11</td>
<td>$12,500</td>
</tr>
<tr>
<td>Family of 12 or More</td>
<td>$12,700</td>
</tr>
</tbody>
</table>

**ELIGIBILITY**

The Plan Administrator assigns Eligibility to all Plan Participants.

**SPECIAL NOTES:**

Out-of-pocket amounts for care received from Network and Non-Network Providers accrue to the Out-of-Pocket maximum.

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

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges; not billed charges.
## COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Network Providers</th>
<th>Non-Network Providers</th>
<th>Retirees with Medicare Network and Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits including surgery performed in an office setting:</td>
<td>90%-10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>• General Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Internal Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• OB/GYN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pediatrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chiropractors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Federally Funded Qualified Rural Health Clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nurse Practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retail Health Clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Assistants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Office Visits including surgery performed in an office setting.</td>
<td>90%-10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Podiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Optometrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Midwife</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Audiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Registered Dietician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sleep Disorder Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alopecia (As a result of a medical condition)</td>
<td>90%-10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Ambulance Services - Ground (For Medically Necessary Transportation only)</td>
<td>90%-10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Ambulance Services - Air (For Medically Necessary Transportation only)</td>
<td>90%-10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Ambulatory Surgical Center and Outpatient Surgical Facility</td>
<td>90%-10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Autism Spectrum Disorders (ASD) (Applied Behavior Analysis (ABA) is not covered for individuals age twenty-one (21) and older.)</td>
<td>90%-10%&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1,3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Birth Control Devices - Insertion and Removal (As listed in the Preventive and Wellness/Routine Care Article in the Benefit Plan.)</td>
<td>100% - 0%</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Network Providers 100% - 0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Network Providers 80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply
## COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Active Employees/Non-Medicare Retirees</th>
<th>Retirees with Medicare Network and Non-Network/Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network Providers</strong></td>
<td><strong>Non-Network Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation <em>(Must begin within six months of qualifying event)</em></td>
<td>90% - 10%(^1,3)</td>
<td>70% - 30%(^1,3)</td>
</tr>
<tr>
<td>Chemotherapy/Radiation Therapy</td>
<td>90% - 10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>90% - 10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities</td>
<td>90% - 10%(^1)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dialysis</td>
<td>90% - 10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices</td>
<td>90% - 10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Emergency Room <em>(Facility Charge)</em></td>
<td>$150 Separate Deductible(^1); Waived if Admitted</td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Services <em>(Non-Facility Charges)</em></td>
<td>90% - 10%(^1)</td>
<td>90% - 10%(^1)</td>
</tr>
<tr>
<td>Eyeglass frames and One pair of Eyeglass Lenses or One Pair of Contact Lenses <em>(Purchased within 6 months following cataract surgery)</em></td>
<td>90% - 10%(^1)</td>
<td>90% - 10%(^1)</td>
</tr>
<tr>
<td>Flu shots and H1N1 vaccines <em>(Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)</em></td>
<td>100% - 0%</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Hearing Aids <em>(Hearing Aids are not covered for individuals age eighteen (18) and older.)</em></td>
<td>90% - 10%(^1,3)</td>
<td>70% - 30%(^1,3)</td>
</tr>
<tr>
<td>Hearing Impaired Interpreter Expense</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

\(^1\) Subject to Plan Year Deductible
\(^2\) Pre-Authorization Required
\(^3\) Age and/or time restrictions apply
## COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Active Employees/Non-Medicare Retirees</th>
<th>Retirees with Medicare Network and Non-Network/Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Tech Imaging – Outpatient</td>
<td>Network Providers</td>
<td>90% -10%(^1)</td>
</tr>
<tr>
<td>• CT Scans</td>
<td>Non-Network Providers</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>• MRA/MRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nuclear Cardiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PET/SPECT Scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90% -10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>80% -20%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Infertility Diagnosis (Benefit is for the initial office visit only. There is no infertility treatment benefit.)</td>
<td>90% -10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Injections Received in a Physician’s Office (When No Other Health Service is Received)</td>
<td>90% -10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Inpatient Hospital Admission, All Inpatient Hospital Services Included</td>
<td>$0 Not Applicable</td>
<td>$50 Copayment 5 Days</td>
</tr>
<tr>
<td>Per Day Copayment</td>
<td>90% -10%(^1,2)</td>
<td>70% - 30%(^1,2)</td>
</tr>
<tr>
<td>Day Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Services</td>
<td>90% -10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Mastectomy Bras - Ortho-Mammary Surgical (Limit of three (3) per Plan Year)</td>
<td>90% -10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Inpatient Treatment Per Day Copayment</td>
<td>$0 Not Applicable</td>
<td>$50 Copayment 5 Days</td>
</tr>
<tr>
<td>Day Maximum</td>
<td>90% -10%(^1,2)</td>
<td>70% - 30%(^1,2)</td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Outpatient Treatment</td>
<td>90% -10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Newborn – Sick, Services Excluding Facility</td>
<td>90% -10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
</tbody>
</table>

\(^1\)Subject to Plan Year Deductible  
\(^2\)Pre-Authorization Required  
\(^3\)Age and/or time restrictions apply
## COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>ACTIVE EMPLOYEES/NON-MEDICARE RETIREESE</th>
<th>RETIRES WITH MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>Newborn – Sick, Facility</td>
<td>$0</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>Per Day Copayment</td>
<td>Not Applicable</td>
<td>5 Days</td>
</tr>
<tr>
<td>Day Maximum</td>
<td>90% - 10%1,2</td>
<td>70% - 30%1,2</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>100% - 0%</td>
<td>70% - 30%1,2</td>
</tr>
<tr>
<td>Oral Surgery for Impacted Teeth</td>
<td>100% - 0%</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Pregnancy Care – Physician Services</td>
<td>90% - 10%1</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td>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.)</td>
<td>100% - 0%3</td>
<td>70% - 30%1,3</td>
</tr>
<tr>
<td>Rehabilitation Services – Outpatient:</td>
<td>90% - 10%1</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td>• Speech (Limit 26 Visits per Plan Year)</td>
<td>90% - 10%1</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td>• Physical/Occupational (Combined limit of 50 Visits per Plan Year. Prior Authorization Required for More Than 50 Visits.)</td>
<td>90% - 10%1</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td>(Visit limits do not apply when services are Provided for Autism Spectrum Disorders)</td>
<td>90% - 10%1</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>90% - 10%1,2</td>
<td>70% - 30%1,2</td>
</tr>
<tr>
<td>Sonograms and Ultrasounds (Outpatient)</td>
<td>90% - 10%1</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ) – Splint Therapy (Surgical treatment for TMJ will only be eligible following a demonstrated failure of splint therapy and upon approval by the Program.)</td>
<td>90% - 10%1</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td></td>
<td>Limit = Lifetime Benefit of $600 for Splint Therapy and Panorex X-ray</td>
<td></td>
</tr>
</tbody>
</table>

1Subject to Plan Year Deductible
2Pre-Authorization Required
3Age and/or time restrictions apply
## PRESCRIPTION DRUGS
*(Administered by OGB’s Pharmacy Benefits Manager)*

<table>
<thead>
<tr>
<th>Service</th>
<th>ACTIVE EMPLOYEES/NON-MEDICARE RETIRES</th>
<th>RETIREES WITH MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NETWORK PROVIDERS</td>
<td>NON-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>90% - 10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Vision Care (Non-Routine) Exam</td>
<td>90% - 10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
<tr>
<td>Vision Care (Routine) Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>X-ray and Laboratory Services</td>
<td>90% - 10%(^1)</td>
<td>70% - 30%(^1)</td>
</tr>
</tbody>
</table>

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1. Subject to Plan Year Deductible
2. Pre-Authorization Required
3. Age and/or time restrictions apply
EXCLUSIONS AND LIMITATIONS

No benefits are provided under this plan for the following:

1. Injury compensable under any worker’s compensation program, regardless of whether the patient has filed a claim for benefits. This applies to compensation provided on an expense-incurred basis or blanket settlements for past and future losses.

2. 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.

3. Expenses for elective, non-therapeutic voluntary abortions (abortions performed for reasons other than to save the life of the mother).

4. Injuries sustained by a Covered Person while in an aggressor role.

5. Expenses incurred as a result of a Covered Person’s commission or attempted commission of an illegal act.

6. 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.

7. Shoes and related items, such as wedges, cookies, and arch supports.

8. 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 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 the Program’s requirements;
   d. Treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in 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 fail under the guidelines of treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral and maxillofacial surgeries which are shown to the satisfaction of the Program to be Medically Necessary, non-dental, non-cosmetic procedures.

9. 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.

10. Maternity expenses incurred by any person other than the Employee or the Employee’s legal Spouse.

11. 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.

12. Charges for services, supplies, treatment, drugs, and devices which are in excess of the maximum allowable under the Medical Fee Schedule, Outpatient Surgical Facility Fee Schedule, or any other limitations of the Plan.

13. Services, supplies, treatment, drugs, devices, and deluxe medical equipment which are not deemed Medically Necessary by the Claims Administrator.

14. 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.

15. Services and supplies for the treatment of and/or related to gender dysphoria or reverse sterilization.

16. 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.
17. 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.

18. 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, and any items the Program determines are not medical supplies.

19. Administrative fees, interest, penalties or sales tax.

20. Marriage counseling, family relations counseling, divorce counseling, parental counseling, job counseling and career counseling.

21. Charges for Physician services rendered to a Covered Person over the telephone or in a non-face-to-face setting.

22. Radial keratotomy, laser surgery, and any other procedures, services or supplies for the correction of refractive errors of the eyes.

23. Services, supplies, surgeries, and treatments for excess body fat, resection of excess skin and/or fat following weight loss or pregnancy, and/or obesity, and morbid obesity. (This exclusion does not apply to Plan Participants who are enrolled in the Plan’s HEADS UP! Program for morbid obesity. Treatment or expenses related to complications from morbid obesity surgery are covered by the Plan. The exclusion for removal of excess fat or skin continues to apply to all Plan Participants.)

24. Hearing aids and any examination to determine the fitting or necessity of hearing aids, except as specifically provided for in Benefit Plan.

25. Hair plugs and/or transplants.

26. Routine physical examinations and/or immunizations not provided for under this Benefit Plan.

27. Routine eye examinations, glasses and contact lenses, except as specifically provided for in this Benefit Plan.

28. Diagnostic or treatment measures that are not recognized as generally accepted medical practice.

29. Medical supplies not specifically provided for in this Benefit Plan.

30. Treatment or services for mental health and substance abuse provided outside the treatment plan developed by the contracted behavioral health provider or non-network provider.

31. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or required by law.

32. Services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.).

33. Services rendered by a Physician or other health care Provider related to the patient by blood, adoption or marriage.

34. Expenses for services rendered by a Physician or other health care 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.

35. 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.

36. Glucometers.

37. Augmentative communication devices.

38. Charges to obtain medical records or any other information needed and/or required to adjudicate a claim.

39. Charges greater than the global allowance for any laboratory, pathology or radiological procedure.

40. Services of a licensed speech therapist when services are not prescribed by a Physician and prior authorization is not obtained.

41. 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.
This Annual Enrollment Guide is presented for general information only. It is not a benefit plan, nor intended to be construed as the Blue Cross benefit plan document. If there is any discrepancy between this Annual Enrollment Guide and the Blue Cross benefit plan document and Schedule of Benefits, the FINAL Blue Cross benefit plan document and Schedule of Benefits will govern the benefits and plan payments.
HMO
Health Maintenance Organizations
SCHEDULE OF BENEFITS

Lifetime Maximum Benefit: ........................................................................................................ Unlimited

Benefit Period: ...................................................................................................................... 01/01/2014 – 12/31/2014

Deductible Amount per Benefit Period:

Individual:
- Network Preferred Care: ........................................................................................................ $0.00
- Non-Network/All Other Providers: ...................................................................................... $1,000.00

Family Unit Maximum:
- Network Preferred Care: .................................................................................................... $0.00
- Non-Network/All Other Providers: ................................................................................... $3,000.00

Maximum Out-of-Pocket Amount per Benefit Period (Includes all eligible Copayments, Coinsurance Amounts and Deductibles):

Individual:
- Network Providers: .......................................................................................................... $1,000.00
- Non-Network Providers: .................................................................................................... $4,000.00

Family:
- Network Providers: .......................................................................................................... $3,000.00
- Non-Network Providers: ................................................................................................... $12,000.00

SPECIAL NOTES:
When the maximum 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.

If the Plan Participant uses a combination of Network and Non-Network Providers, Out-of-Pocket amounts for care received from Non-Network Providers will accrue to the Network Out-of-Pocket maximum; however, Network Out-of-Pocket amounts will not accrue to the Non-Network Out-of-Pocket maximum.

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges; not billed charges.

ELIGIBILITY

The Plan Administrator assigns Eligibility to all Plan Participants.
### COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th>Services Description</th>
<th>ACTIVE EMPLOYEES/NON-MEDICARE RETIREES</th>
<th>RETIREES WITH MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Office Visits including surgery performed in an office setting:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- General Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Family Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Internal Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- OB/GYN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chiropractors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Federally Funded Qualified Rural Health Clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Nurse Practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Retail Health Clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician Assistants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Office Visits including surgery performed in an office setting:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Podiatrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Optometrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Audiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Registered Dietician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sleep Disorder Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alopecia – Limited to Two (2) Office Visits per Plan Year (Lab services covered at coinsurance amounts when performed on same day as office visit and by same Provider).</strong></td>
<td>100% - 0%</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td><strong>Ambulance Services - Ground</strong> <em>(For Emergency Medical Transportation only)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services - Air</strong> <em>(For Emergency Medical Transportation only)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulatory Surgical Center and Outpatient Surgical Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autism Spectrum Disorders (ASD)</strong> <em>(Applied Behavior Analysis (ABA) is not covered for individuals age twenty-one (21) and older.)</em></td>
<td>$15/$25 Copayment</td>
<td></td>
</tr>
<tr>
<td><strong>Birth Control Devices - Insertion and Removal</strong> <em>(As listed in the Preventive and Wellness/Routine Care Article in the Benefit Plan.)</em></td>
<td>100% - 0%</td>
<td></td>
</tr>
</tbody>
</table>

1 Subject to Plan Year Deductible
2 Pre-Authorization Required
3 Age and/or time restrictions apply
4 Subject to copayments/coinsurance, if Medicare Deductibles have not been met
## COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Active Employees/Non-Medicare Retirees</th>
<th>Retirees with Medicare Retirees with Medicare Retirees</th>
<th>Network Providers</th>
<th>Non-Network Providers</th>
<th>Network and Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation <em>(Limit of 48 visits per Plan Year)</em></td>
<td>$15/$25 Copayment per day depending on Provider: $25 Copayment – Outpatient Facility</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy/Radiation Therapy</td>
<td>Office - $15 Copayment per Visit: Outpatient Facility 100% - 0%</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities</td>
<td>$15 Copayment</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>100% - 0%</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices</td>
<td>80 – 20%&lt;sup&gt;2&lt;/sup&gt; of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room <em>(Facility Charge)</em></td>
<td>$100 Copayment; Waived if Admitted</td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Services <em>(Non-Facility Charges)</em></td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass frames and One pair of Eyeglass Lenses or One Pair of Contact Lenses <em>(Purchased within 6 months following cataract surgery)</em></td>
<td>Eyeglass Frames - Limited to a Maximum Benefit of $50&lt;sup&gt;3&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu shots and H1N1 vaccines <em>(Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)</em></td>
<td>100% - 0%</td>
<td>100% - 0%</td>
<td>100% - 0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids <em>(Hearing Aids are not covered for individuals age eighteen (18) and older.)</em></td>
<td>80% - 20%&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>Not Covered</td>
<td>100% - 0%&lt;sup&gt;3,4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Impaired Interpreter expense</td>
<td>100% - 0%</td>
<td>Not Covered</td>
<td>Non-Network Providers Not Covered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply  
<sup>4</sup>Subject to copayments/coinsurance, if Medicare Deductibles have not been met
## COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>ACTIVE EMPLOYEES/ NON-MEDICARE RETIREES</th>
<th>RETIREES WITH MEDICARE NETWORK AND NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Tech Imaging – Outpatient</td>
<td>Network Providers: $50 Copayment²</td>
<td>Non-Network Providers: 70% - 30%¹</td>
</tr>
<tr>
<td>• CT Scans</td>
<td></td>
<td>100% - 0%⁴</td>
</tr>
<tr>
<td>• MRA/MRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nuclear Cardiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PET/SPECT Scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% - 0%²</td>
<td>70% - 30%¹</td>
</tr>
<tr>
<td>(Network and Non-Network Providers aggregate to Plan Year Limit)</td>
<td>Limit of 150 Visits per Plan Year</td>
<td>Limit of 150 Visits per Plan Year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% - 0%²</td>
<td>70% - 30%¹</td>
</tr>
<tr>
<td>Infertility Diagnosis</td>
<td>$15/$25 Copayment depending on Provider</td>
<td>100% - 0%⁴</td>
</tr>
<tr>
<td>(Benefit is for the initial office visit only. There is no infertility treatment benefit.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injections Received in a Physician’s Office (When No Other Health Service is Received)</td>
<td>100% - 0%</td>
<td>70% - 30%¹</td>
</tr>
<tr>
<td>Inpatient Hospital Admission, All Inpatient Hospital Services Included</td>
<td>$100 Copayment per day², Maximum of $300 per Admission</td>
<td>100% - 0%⁴</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Services for Which a Copayment is Not Applicable</td>
<td>100% - 0%¹</td>
<td>70% - 30%¹</td>
</tr>
<tr>
<td>Mastectomy Bras - Ortho-Mammary Surgical (Limited to two (2) per Plan Year)</td>
<td>80 – 20%² of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year</td>
<td>100% - 0%⁴</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Inpatient Treatment</td>
<td>$100 Copayment per day², Maximum of $300 per Admission</td>
<td>100% - 0%⁴</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Outpatient Treatment</td>
<td>$15 Copayment per Visit</td>
<td>100% - 0%⁴</td>
</tr>
<tr>
<td>Newborn – Sick, Services, excluding Facility</td>
<td>100% - 0%</td>
<td>100% - 0%⁴</td>
</tr>
<tr>
<td>Newborn – Sick, Facility</td>
<td>$100 Copayment per day², Maximum of $300 per Admission</td>
<td>100% - 0%⁴</td>
</tr>
</tbody>
</table>

¹Subject to Plan Year Deductible
²Pre-Authorization Required
³Age and/or time restrictions apply
⁴Subject to copayments/coinsurance, if Medicare Deductibles have not been met
### COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Active Employees/Non-Medicare Retirees</th>
<th>Retirees with Medicare Network and Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery</td>
<td>$25 Copayment</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Pregnancy Care – Physician Services</td>
<td>$90 Copayment per pregnancy</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>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.)</td>
<td>100% -0%</td>
<td>100% -0%</td>
</tr>
<tr>
<td>Rehabilitation Services – Outpatient:</td>
<td>$15 Copayment per Visit regardless of Provider type or location</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Skilled Nursing Facility - Network and Non-Network Providers aggregate to the Plan Year Maximum</td>
<td>$100 Copayment per day², Maximum of $300 per Admission</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Sonograms and Ultrasounds (Outpatient)</td>
<td>$25 Copayment</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ) – Splint Therapy</td>
<td>$15/$25 Copayment depending on Provider</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$25 Copayment</td>
<td>100% - 0%</td>
</tr>
</tbody>
</table>

1. Subject to Plan Year Deductible
2. Pre-Authorization Required
3. Age and/or time restrictions apply
4. Subject to copayments/coinsurance, if Medicare Deductibles have not been met
COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th>Vision Care (Non-Routine) Exam</th>
<th>ACTIVE EMPLOYEES/NON-MEDICARE RETIrees</th>
<th>RETIrees WITH MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>$15/$25 Copayment depending on Provider</td>
<td>70% - 30%¹</td>
<td>100% - 0%⁴</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision Care (Routine) Exam</th>
<th>$15/$25 Copayment² depending on Provider</th>
<th>Not covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limit of One(1) Exam per Plan Year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| X-ray and Laboratory Services | 100% - 0% | 70% - 30%¹ | 100% - 0%⁴ |

PRESCRIPTION DRUGS (Administered by OGB’s Pharmacy Benefits Manager)

<table>
<thead>
<tr>
<th>Maximum Copayment</th>
<th>ACTIVE EMPLOYEES/NON-MEDICARE RETIrees</th>
<th>RETIrees WITH MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NETWORK PROVIDERS</td>
<td>NON-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>$50 maximum per 31-day prescription dispensed:</td>
<td>$100 maximum per 32-62 days prescription dispensed: $150 maximum per 63-93 days prescription dispensed: Same for Retail and Mail Order</td>
<td>NON-NETWORK IN-STATE: Reimbursement limited to 50% of amount payable by Plan at Network Pharmacy; Non-NETWORK OUT-OF-STATE: Reimbursement limited to 80% of amount payable by Plan at Network Pharmacy</td>
</tr>
</tbody>
</table>

| Maximum Out-of-Pocket | $1,200 per person, per Plan Year⁳ |
|                       | $1,200 per person, per Plan Year⁶ |

| Copayment after Threshold is Reached | $15 maximum - Brand per 1-31 day supply; $30 maximum - Brand per 32-62 day supply; $45 maximum - Brand per 63-93 day supply: No copayment - Generic (Plan pays balance of Eligible Expenses) |
|                                   | $15 maximum - Brand per 1-31 day supply; $30 maximum - Brand per 32-62 day supply; $45 maximum - Brand per 63-93 day supply: No copayment - Generic (Plan pays balance of Eligible Expenses)³ |

¹Subject to Plan Year Deductible  
²Pre-Authorization Required  
³Age and/or time restrictions apply  
⁴Subject to copayments/coinsurance, if Medicare Deductibles have not been met
EXCLUSIONS AND LIMITATIONS

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, the following are not covered, REGARDLESS OF CLAIM OF MEDICAL NECESSITY:

1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. 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.

2. Any charges exceeding the Allowable Charge.

3. 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.

4. 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. to the extent payment has been made or is available under any other contract issued by Blue Cross and Blue Shield of Louisiana or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law;
   e. paid or payable under Medicare Parts A or B when a Plan Participant has Medicare, except when Medicare Secondary Payer provisions apply;
   f. 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 for such determinations;
   g. rendered as a result of occupational disease or injury compensable under any Workers Compensation Law subject to the provisions of La. R.S. 23:1205(C);
   h. rendered by a Provider who is the Plan Participant's spouse, child, stepchild, parent, stepparent or grandparent.

5. 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 for injuries or illnesses found by the Secretary of Veterans’ Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;
   c. those occurring as a result of taking part in a riot or acts of civil disobedience;
   d. those occurring as a result of a Plan Participant's commission or attempted commission of a felony; or
   e. for treatment of any Plan Participant confined in a prison, jail, or other penal institution.

6. Services, surgery, supplies, treatment or expenses for the following REGARDLESS OF CLAIM OF MEDICAL NECESSITY:
   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. gynecomastia;
   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;
   f. implantation, removal and/or re-implantation of penile prosthesis and services;
   g. diastasis recti;
   h. biofeedback;
   i. lifestyle/habit changing clinics and/or programs;
EXCLUSIONS AND LIMITATIONS

j. treatment related to sex transformations, or sexual inadequacies, except for the Diagnosis and/or treatment of sexual dysfunction/impotence;

k. 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;

l. recreational therapy;

m. services performed primarily to enhance athletic abilities;

7. 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. hair pieces, wigs, hair growth and/or hair implants;

e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or

f. visual therapy;

8. 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); or

d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.

9. Regardless of Medical Necessity services, Surgery, supplies, treatment or expenses related to:

a. weight reduction programs;

b. removal of excess fat or skin or services at a health spa or similar facility; or

c. obesity or morbid obesity, regardless of Medical Necessity.

This exclusion does not apply to Plan Participants who are enrolled in the Plan’s HEADS UP! program for morbid obesity. Treatment or expenses related to complications from morbid obesity surgery are covered by the Plan. The exclusion for removal of excess fat or skin or services at a health spa or similar facility continue to apply to all Plan Participants.

10. 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.

11. 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.

12. Vitamins, dietary supplements and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU)).

13. Investigational drugs and drugs used other than for the FDA approved indication, 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 and all Medically Necessary services associated with the administration of the drug. These drugs may be covered by OGB’s Pharmacy Benefit Administrator. Please refer to the Schedule of Benefits or call the Pharmacy Administrator at the telephone number on the back of the Plan Participant ID card.

14. Sales tax or interest.

15. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Plan Participant’s home or vehicle.
16. Charges for the delivery of health care, diagnosis, consultation, or treatment of a Member, unless the Provider is physically present with the Member at the time services are rendered, are not covered unless approved by Us. Charges for the delivery of health care, diagnosis, consultation, or treatment of a Member using technology, including but not limited to audio and video transmission, telephone, or email are not covered unless approved by Us.

17. 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.

18. Routine foot care; palliative or cosmetic care or treatment; treatment of flat feet, except for persons who have been diagnosed with diabetes; cutting or removal of corns and calluses; nail trimming or debriding, or supportive devices of the foot.

19. 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.

20. Services or supplies related to the diagnosis and treatment of infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits.

21. 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 intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.

22. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.

23. Pregnancy for Dependents (except dependent spouses) is limited to services necessary to treat complications of pregnancy.

24. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services, except as specifically provided in this Benefit Plan.

25. Cosmetic Surgery, procedures, services, supplies or treatment for cosmetic purposes, unless required for a Congenital Anomaly.

26. Dental Care and Treatment, dental appliances, Orthodontic services, oral splints, oral implants and orthognathic surgery except as specifically provided in this Benefit Plan. Dental exams and x-rays needed to diagnose impacted teeth are not covered. See the Oral Surgery Article of this Benefit Plan for more information.

27. 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.

28. 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.

29. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.

30. 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 exclusion for educational services and supplies does not apply to training and education for diabetes.

31. Admission to a Hospital primarily for Diagnostic Services which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician’s office.


33. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.
34. Immunizations required for foreign travel.
35. Counseling services such as career counseling, divorce counseling, parental counseling, job counseling, and marital/family counseling services.
36. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan.
37. Medical and Surgical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP).
38. Paternity tests and tests performed for legal purposes.
39. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or required by law.
40. Reversal of a voluntary sterilization procedure.
41. Any Durable Medical Equipment, items and supplies over reasonable quantity limits as determined by the Plan; all defibrillators other than implantable defibrillators authorized by the Claims Administrator.
42. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
43. Services or supplies for the prophylactic storage of cord blood.
44. 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.
45. Sleep studies, unless performed in the home or performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM). If a sleep study is performed in a sleep laboratory that is not accredited by one of these bodies, or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.
46. Applied Behavior Analysis (ABA) that the Company has determined is not Medically Necessary. 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 Behavior Analyst Certification Board or rendered by a Provider that has not provided, to the satisfaction of Company, documented evidence of equivalent education, professional training, and supervised experience in ABA. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.
47. Services provided in a Residential Treatment Center for the active treatment of specific impairments of Mental Health or substance abuse, except as specifically provided in this Benefit Plan.
48. 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. lactation therapy
   k. sensory integration therapy
This Annual Enrollment Guide is presented for general information only. It is not a benefit plan, nor intended to be construed as the Blue Cross benefit plan document. If there is any discrepancy between this Annual Enrollment Guide and the Blue Cross benefit plan document and Schedule of Benefits, the FINAL Blue Cross benefit plan document and Schedule of Benefits will govern the benefits and plan payments.
CDHP-HSA
Consumer Driven Health Plan – Health Savings Account
SCHEDULE OF BENEFITS

Lifetime Maximum Benefit: .................................................................................................................... Unlimited

Benefit Period: ................................................................................................................................. 01/01/14 – 12/31/14

Deductible Amount per Benefit Period:

- Employee Only Deductible Amount: ................................................................................................... $1,250.00
- Employee Plus One Deductible Amount (Spouse or Child): ............................................................. $2,500.00
- Family Deductible Amount: ................................................................................................................ $3,000.00

Coinsurance:

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Plan Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-Network Providers</td>
<td>70%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Maximum Out-of-Pocket Amount Benefit Period:

<p>| | | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$3,250.00</td>
<td>$3,250.00</td>
</tr>
<tr>
<td>Employee Plus One</td>
<td>$6,500.00</td>
<td>$6,500.00</td>
</tr>
<tr>
<td>Family of 3</td>
<td>$9,000.00</td>
<td>$9,000.00</td>
</tr>
<tr>
<td>Family of 4</td>
<td>$11,000.00</td>
<td>$11,000.00</td>
</tr>
<tr>
<td>Family of 5 or More</td>
<td>$11,900.00</td>
<td>$11,900.00</td>
</tr>
</tbody>
</table>

SPECIAL NOTES:

Out-of-Pocket amounts for services received from a Network Provider that accrue to the Out-of-Pocket Amount for Network Providers will not count toward the Out-of-Pocket Amount for Non-Network Providers.

Out-of-Pocket amounts for services received from a Non-Network Provider that accrue to the Out-of-Pocket Amount for Non-Network Providers will not count toward the Out-of-Pocket Amount for Network Providers.

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges; not billed charges.

ELIGIBILITY

The Plan Administrator assigns Eligibility to all Plan Participants.
# COINSURANCE

<table>
<thead>
<tr>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician’s Office Visits including surgery performed in an office setting:</strong>&lt;br&gt;• General Practice&lt;br&gt;• Family Practice&lt;br&gt;• Internal Medicine&lt;br&gt;• OB/GYN&lt;br&gt;• Pediatrics&lt;br&gt;• Chiropractors&lt;br&gt;• Federally Funded Qualified Rural Health Clinics&lt;br&gt;• Retail Health Clinics&lt;br&gt;• Nurse Practitioner&lt;br&gt;• Physician’s Assistant</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Specialist’s Office Visits including surgery performed in an office setting:</strong>&lt;br&gt;• Physician&lt;br&gt;• Podiatrist&lt;br&gt;• Optometrist&lt;br&gt;• Midwife&lt;br&gt;• Audiologist&lt;br&gt;• Registered Dietician&lt;br&gt;• Sleep Disorder Clinic</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Alopecia</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ambulance Services&lt;br&gt;(For Emergency Medical Transportation Only)&lt;br&gt;• Ground Transportation&lt;br&gt;• Air Ambulance</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Ambulatory Surgical Center and Outpatient Surgical Facility</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Autism Spectrum Disorders (ASD) – Office Visits&lt;br&gt;(Applied Behavior Analysis (ABA) is not covered for individuals age twenty-one (21) and older.)</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Autism Spectrum Disorders (ASD) – Inpatient Hospital</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Birth Control Devices - Insertion and Removal&lt;br&gt;(As listed in the Preventive and Wellness/Routine Care Article in the Benefit Plan.)</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Cardiac Rehabilitation&lt;br&gt;(Must begin within six months of qualifying event. Limited to 26 visits per Plan Year)</td>
<td>80% - 20%&lt;sup&gt;1,3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply
<table>
<thead>
<tr>
<th>Service</th>
<th>Network Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy/Radiation Therapy</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Diabetic/Nutritional Counseling Clinics and Outpatient Facilities</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dialysis</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Emergency Room (Facility Charge)</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Emergency Medical Services (Non-Facility Charge)</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Flu Shots and H1N1 vaccines (Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)</td>
<td>100% - 0%</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older)</td>
<td>80% - 20%&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hearing Impaired Interpreter Expense</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>High-Tech Imaging – Outpatient (CT Scans, MRI/MRA, Nuclear Cardiology, PET/SPECT Scans)</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Home Health Care (Limit of 60 Visits per Plan Year, Combination of Network and Non-Network) (One Visit = 4 hours)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hospice Care (Limit of 360 Visits for entire period covered under Plan, Combination of Network and Non-Network)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Infertility Diagnosis</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Injections Received in a Physician’s Office (When no other health services are received)</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt; per injection</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt; per injection</td>
</tr>
<tr>
<td>Inpatient Hospital Admission (All Inpatient Hospital services included)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Services</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply
<table>
<thead>
<tr>
<th>Service</th>
<th>COINSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastectomy Bras - Ortho-Mammary Surgical</td>
<td>NETWORK PROVIDERS: 80% - 20% (^1) \quad NON-NETWORK PROVIDERS: 70% - 30% (^1)</td>
</tr>
<tr>
<td>(Limited to two (2) per Plan Year)</td>
<td></td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Inpatient Treatment</td>
<td>NETWORK PROVIDERS: 80% - 20% (^{1,2}) \quad NON-NETWORK PROVIDERS: 70% - 30% (^{1,2})</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Outpatient Treatment</td>
<td>NETWORK PROVIDERS: 80% - 20% (^1) \quad NON-NETWORK PROVIDERS: 70% - 30% (^1)</td>
</tr>
<tr>
<td>Newborn – Sick, Services Excluding Facility</td>
<td>NETWORK PROVIDERS: 80% - 20% (^1) \quad NON-NETWORK PROVIDERS: 70% - 30% (^1)</td>
</tr>
<tr>
<td>Newborn – Sick, Facility</td>
<td>NETWORK PROVIDERS: 80% - 20% (^{1,2}) \quad NON-NETWORK PROVIDERS: 70% - 30% (^{1,2})</td>
</tr>
<tr>
<td>Oral Surgery for Impacted Teeth</td>
<td>NETWORK PROVIDERS: 80% - 20% (^1) \quad NON-NETWORK PROVIDERS: 80% - 20% (^1)</td>
</tr>
<tr>
<td>Pregnancy Care – Physician Services</td>
<td>NETWORK PROVIDERS: 80% - 20% (^1) \quad NON-NETWORK PROVIDERS: 70% - 30% (^1)</td>
</tr>
<tr>
<td>Preventive Care – Services include screening to detect illness or</td>
<td>NETWORK PROVIDERS: 100% - 0% (^3) \quad NON-NETWORK PROVIDERS: 100% - 0% (^3)</td>
</tr>
<tr>
<td>health risks during a Physician office visit. The covered services are</td>
<td>Plan Participant pays the difference between the billed amount and the fee schedule amount.</td>
</tr>
<tr>
<td>based on prevailing medical standards and may vary according to age</td>
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<tr>
<td>and family history. (For a complete list of benefits, refer to the</td>
<td></td>
</tr>
<tr>
<td>Preventive and Wellness/Routine Care Article in the Benefit Plan.)</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services – Outpatient:</td>
<td></td>
</tr>
<tr>
<td>• Physical (Limit 50 Visits per Plan Year)</td>
<td>NETWORK PROVIDORS: 80% - 20% (^1) \quad NON-NETWORK PROVIDERS: 70% - 30% (^1)</td>
</tr>
<tr>
<td>• Speech (Limit 26 Visits per Plan Year)</td>
<td></td>
</tr>
<tr>
<td>• Occupational (Limit 30 Visits per Plan Year)</td>
<td></td>
</tr>
<tr>
<td>• Pulmonary Therapies (Limit 30 Visits per Plan Year)</td>
<td></td>
</tr>
<tr>
<td>(Visit limits are combination of Network and Non-Network Benefits;</td>
<td></td>
</tr>
<tr>
<td>Visit limits do not apply when services are provided for Autism</td>
<td></td>
</tr>
<tr>
<td>Spectrum Disorders.)</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>NETWORK PROVIDERS: 80% - 20% (^{1,2}) \quad NON-NETWORK PROVIDERS: 70% - 30% (^{1,2})</td>
</tr>
<tr>
<td>Sonograms and Ultrasounds - Outpatient</td>
<td>NETWORK PROVIDERS: 80% - 20% (^1) \quad NON-NETWORK PROVIDERS: 70% - 30% (^1)</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ)</td>
<td>NETWORK PROVIDERS: Not Covered \quad NON-NETWORK PROVIDERS: Not Covered</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>NETWORK PROVIDERS: 80% - 20% (^1) \quad NON-NETWORK PROVIDERS: 70% - 30% (^1)</td>
</tr>
</tbody>
</table>

\(^1\) Subject to Plan Year Deductible  
\(^2\) Pre-Authorization Required  
\(^3\) Age and/or time restrictions apply
Blue Cross and Blue Shield of Louisiana contracts with Express Scripts (ESI) to process pharmacy claims on its behalf. For ESI’s list of generic, preferred brand, non-preferred brand, specialty and maintenance/preventive drugs go to [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb).

ESI has a robust pharmacy network which consists of a large group of conveniently located participating pharmacies as well as an optional mail-service program. You may use any pharmacy you wish, but there are advantages to selecting a participating network pharmacy:

- Lower costs
- No claims to file
- No waiting for reimbursement

**Prescription Drugs (Administered by Express Scripts)**

**COINSURANCE**

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<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Care (Non-Routine) Exam</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Vision Care (Routine) Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>X-Ray and Laboratory Services</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply

**Retail and Mail Order:**
Subject to deductible; copayments
$10 Copayment - Generic  
$25 Copayment - Preferred Brand  
$50 Copayment - Non-preferred Brand  
$50 Copayment - Specialty  
31-day supply for one copayment  
62-day supply for two copayments  
93-day supply for three copayments  
Maintenance drugs:  
Not subject to deductible; subject to applicable copayments above.

**PRESCRIPTION DRUG PROGRAM**

*Administered by Express Scripts (ESI)*
EXCLUSIONS AND LIMITATIONS

Benefits are not available for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in this Benefit Plan.

A. ALTERNATIVE TREATMENTS

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage Therapy, unless performed by a licensed massage therapist.
5. Rolfing.
6. Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM).

B. COMFORT OR CONVENIENCE

1. Television.
2. Telephone.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   a. Air conditioners
   b. Air purifiers and filters
   c. Batteries and battery chargers
   d. Dehumidifiers
   e. Humidifiers
5. Devices and computers to assist in communication and speech.

C. DENTAL

1. Dental care except as described in this Benefit Plan
2. 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
3. Dental implants.
4. Dental braces.
5. 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 immunosuppresives
   c. The direct treatment of acute traumatic Injury, cancer or cleft palate
6. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

D. EXPERIMENTAL AND INVESTIGATIONAL SERVICES

Experimental and Investigational Services are excluded. The fact that an Experimental or Investigational service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational in the treatment of that particular condition.
**EXCLUSIONS AND LIMITATIONS**  

**E. FOOT CARE**

1. Routine foot care, including: the cutting or removal of corns and calluses, nail trimming, cutting, or debriding, or supportive devices of the foot, except for persons who have been diagnosed with diabetes.

2. Hygienic and preventive maintenance foot care. Examples include the following:
   - Cleaning and soaking the feet;
   - Applying skin creams in order to maintain skin tone;
   - Other services that are performed when there is not a localized illness, injury or symptom involving the foot;

3. Treatment of flat feet;

4. Shoe orthotics.

**F. MEDICAL SUPPLIES AND APPLIANCES**

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings;
   - Ace bandages;
   - Gauze and dressings;
   - Ostomy supplies;
   - Syringes; and
   - Diabetic test strips.

3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces.)

4. Tubing and masks are not covered except when used with Durable Medical Equipment as described in the Other Covered Services Article.

**G. MENTAL HEALTH/SUBSTANCE ABUSE**


2. Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.

3. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Claims Administrator.

4. 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:
   - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
   - 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;
   - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective;
   - not consistent with the level of care guidelines or best practices as modified from time to time, or
   - not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient’s Mental Illness, Substance Abuse disorder or condition based on generally accepted standards of medical practice and benchmarks.
EXCLUSIONS AND LIMITATIONS

5. 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*.

6. Mental Health Services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.

7. 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.

8. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

9. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.

10. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

11. Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.


13. Substance Use Disorder Services for the treatment of nicotine or caffeine use.

14. Pastoral counseling.

H. NUTRITION

1. Megavitamin and nutrition based therapy.

2. Nutritional counseling for either individuals or groups.

3. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

I. PHYSICAL APPEARANCE

1. Cosmetic Procedures. Examples include:
   a. Pharmacological regimens, nutritional procedures or treatments;
   b. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other skin abrasion procedures); and
   c. Skin abrasion procedures performed as a treatment for acne.

2. 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.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

5. Wigs regardless of the reason for the hair loss.

J. PRESCRIPTION DRUGS

All limitations and exclusions detailed in the Prescription Drug Article of the Benefit Plan.
EXCLUSIONS AND LIMITATIONS Continued

K. PROVIDERS

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. 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 is not actively involved in the Plan Participant’s care after the service is received.

This exclusion does not apply to mammography testing.

L. REPRODUCTION

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Health services and associated expenses for elective abortion.
5. Fetal reduction surgery.
6. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.

M. SERVICES PROVIDED UNDER ANOTHER PLAN

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers’ compensation, no-fault auto insurance, or similar legislation.
   If coverage under workers’ compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or mental illness that would have been covered under workers’ compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. TRANSPLANTS

1. Health services for organ, multiple organ and tissue transplants, except as defined in the Benefit Plan.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient’s Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Blue Distinction Center for Transplants for the specific organ or transplant or a transplant facility in the Blue Cross and Blue Shield Preferred Provider Network.
5. Any solid organ transplant that is performed as a treatment for cancer.
O. TRAVEL
1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel Expenses related to covered transplantation services may be reimbursed at the Plan Administrator’s sole discretion.

P. VISION AND HEARING
1. Purchase cost of hearing aids, eye glasses or contact lenses.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy.
4. 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.
5. Routine vision examinations, including refractive examinations.

Q. ALL OTHER EXCLUSIONS
1. Health services and supplies that do not meet the definition of a Covered Health Service as defined in this Benefit Plan.
2. 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.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. 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.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
10. Non-surgical treatment of obesity, including morbid obesity. This exclusion does not apply to Plan Participants who are enrolled in the Plan’s HEADS UP! program for morbid obesity.
11. Surgical treatment of obesity including severe morbid obesity (with a BMI greater than 35). This exclusion does not apply to Plan Participants who are enrolled in the Plan’s HEADS UP! program for morbid obesity. Treatment or expenses related to complications from morbid obesity surgery are covered by the Plan.
12. Growth hormone therapy.
13. Sex transformation operations.
15. Domiciliary care.
16. Private duty nursing.
17. Respite care.
18. Rest cures.
20. Treatment of benign gynecomastia (abnormal breast enlargement in males).
21. Medical and surgical treatment of excessive sweating (hyperhidrosis).
22. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to breast reconstruction following a mastectomy as described in the Benefit Plan.
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

25. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
26. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.
29. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or required by law.
WILL YOU NEED A HEALTH SAVINGS ACCOUNT?

OGB will continue to offer a consumer driven health plan with a Health Savings Account (CDHP-HSA) option for the 2014 plan year.

Employees who enroll in the CDHP may also choose to open an HSA and use pre-tax dollars to make contributions to the HSA. The HSA can be used to pay eligible medical and pharmacy expenses for you and your family until you meet your deductible and any applicable copayments once you meet your deductible. It can also help you save for future health care expenses.

If you choose to utilize the HSA option, the state will contribute $200 at the start of the plan year to help jump-start your savings—and will match your tax-free contributions made through payroll deduction dollar for dollar, up to an additional $575 per plan year for a total of $775 per plan year. For the 2014 calendar year, the U.S. Internal Revenue Service limits total tax-free HSA contributions to $3,300* for employee coverage and $6,550 for family coverage—plus an additional $1,000 if you are age 55 or older. To receive these matching dollars, however, you must set up an HSA through Bancorp Bank** by completing a MySmart$aver HSA application through your agency’s human resources office. If you currently have an HSA with another bank, you may roll your funds to MySmart$aver HSA.

In addition to enabling you to receive up to $775 in contributions from the state, participating in the HSA also reduces the amount of taxes you pay. You pay no taxes on money you contribute to your HSA option (via payroll deduction) or on contributions from the state and interest earned on the account is not taxed. Because you own the HSA, you decide when and how to spend the money. You can use the tax-free dollars in your HSA to pay eligible medical and pharmacy expenses now, or you can pay these expenses out-of-pocket and let your HSA grow.

Unlike a Health Care Flexible Spending Arrangement (HCFSA) with a use-or-lose rule, you are not required to spend your entire annual HSA contribution. Instead, your money can remain in your HSA and earn interest—tax-free—from year to year.

If you change health plans or jobs, or you retire, the HSA is yours to keep. And from age 65 on, you can use your HSA dollars for any health care or non-health care expense with no penalty, although any amount used for non-health care expenses will be taxable as income.

*These amounts are for 2013, may change annually, and are subject to additional IRS rules. Check with your tax advisor.
**Bancorp Bank, which owns MySmart$aver, is an independent company that provides HSA options to Blue Cross and Blue Shield of Louisiana customers.
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

What’s included as part of your OGB health plan?

Magellan Behavioral Health manages the mental health and substance abuse benefits that are part of your OGB health plan. You and your covered dependents can receive outpatient, inpatient, partial hospitalization and residential treatment for mental health and substance abuse problems with Magellan.

Here are some things you should know about Magellan and your benefits:

**Getting the Best Care with Magellan’s Help**

Magellan will help you get high-quality care with your needs in mind – giving you a better experience. By using Magellan, you get:

- **Careful Care Management** – Magellan’s licensed mental health doctors, nurses and other providers help you find a provider and a treatment plan that will work best for you and your dependents.

- **Coordinating of Care** – Magellan works with health plans and employers to understand your needs and to create treatment programs that will meet those needs.

- **High-Quality Care** – Magellan studies what care works best and compares results to help make your quality of care even stronger.

**Network Providers**

You can go to the Blue Cross Preferred Care behavioral health network of doctors and other mental health providers for your care.

**Authorizations for Care**

Magellan is responsible for all mental health and substance abuse authorizations. Your doctor or provider must check with Magellan before you get care. This is true for all care, except outpatient care.

**Learn More**

Go online or call us to find out if your doctor is in your Blue Cross Preferred Care behavioral health network or to ask about your benefits:

**ONLINE:**

[www.bcbsla.com/ogb](http://www.bcbsla.com/ogb)

Click on **OGB Find Care**

Read more under **Mental Health Substance Abuse Benefits**

**CALL:**

Blue Cross Customer Service

1-800-392-4089

Monday – Friday

8 a.m. - 5 p.m.
Preferred Care Provider Network = Extra Savings

Our Preferred Care Provider network is just that – a select group of hospitals, physicians and allied providers that have contracted with Blue Cross to offer special discounts to our customers. When a “preferred provider” who is a member of our network is used, we can pass the savings on to you by offering a higher level of benefits to you and your dependents.

A majority of hospitals and physicians in the state, as well as allied providers, participate in our preferred provider network, making our network among the most extensive available in Louisiana. Should you choose to receive medical services outside the Preferred Care Provider network, benefits will still be paid, but at a lower level.

How to Search for a Blue Cross Preferred Care Provider in Louisiana

To search for a Blue Cross Preferred Care provider within the state of Louisiana, go to www.bcbsla.com/ogb and click on “Louisiana Provider Directory.”

1. This will bring you to the Doctor & Hospital Search page.
2. Step 1 is pre-populated with OGB Preferred Care 2013, in the box marked “Network.”
3. Step 2 allows you to enter a name, specialty, city, parish and/or ZIP code as the search criteria.
4. Click on the “Search” button.

5. You may refine your search results by Radius, Provider Type, Specialty, Parish, Availability, Languages Spoken, Gender, Admitting Hospitals, Board Certification and/or Certifications & Recognition.
6. To view your search results, you may sort by City A–Z, City Z–A, Name A–Z, or Name Z–A. You may compare multiple providers by checking the box under “Compare.”

Talking to Your Louisiana Provider about the Blue Cross HMO Plan

Tell your doctor or his/her staff that you are a state of Louisiana employee or retiree and that the Blue Cross HMO Plan is offered through the Blue Cross Preferred Care network, not the subsidiary HMO Louisiana network.

Call Customer Service at 1.800.392.4089

If you have any trouble locating a provider or if you have any questions, Customer Service is available 8 a.m. to 5 p.m., Monday through Friday.
Benefits That Travel

The BlueCard® Program is a national program that allows our members to receive healthcare services while traveling or living in another Blue Plan’s service area. The program links participating healthcare providers with the independent Blue Plans across the country through a single electronic network. Our members have peace of mind knowing they’ll find the care they need if they get sick or injured on the road.

How to Search for a National BlueCard® Provider

To search for a provider outside of the state of Louisiana, go to www.bcbsla.com/ogb and click on “National Provider Directory.”

1. This will bring you to the National Doctor and Hospital Finder.
2. To see doctors and hospitals in your network, enter “OGS” as the first three letters of your member ID.
3. Search for providers by name, specialty, and radius. The page opens with your current location or you may enter a different location.
4. Click on the “GO” button to continue.

Talking to Your National Provider about the Blue Cross HMO Plan

If you are not sure whether a doctor outside of the state of Louisiana is in the Blue Cross national network, simply call your doctor’s office directly.

Tell your doctor or his/her staff that you have access to the BlueCard PPO network when traveling or living outside of Louisiana.

Call Customer Service at 1.800.392.4089

If you have any trouble locating a provider, or if you or your doctors have any questions, Customer Service is available 8 a.m. to 5 p.m., Monday through Friday.

National Doctor and Hospital Finder mobile Apps are currently available on the iPhone and Android platforms. Free App downloads and more information can be found on www.bcbs.com/mobile.
The Blue Cross PPO, HMO and CDHP are strengthened by our Care Management programs that ensure your care is appropriate. Our team of doctors and nurses oversees our members’ care through the following functions:

**Authorization of Elective Admissions and Other Covered Services**

If you need to be hospitalized for a condition other than an emergency, your admission to the hospital requires “authorization.” Patients, physicians, hospitals and our Care Management Department all participate in the authorization process that is used to determine whether hospitalization is necessary and an appropriate length of stay.

Certain services and visits to certain providers require authorization from Blue Cross before services can be performed. A comprehensive authorization list is included in the Authorization Requirements section of the guide.

**Case Management**

The Case Management Program works to coordinate the benefits with the physician’s care during and following an acute illness episode including long-term goals for members with certain conditions. Through this program, we may often:

- Help resolve issues that block your path to good health
- Help you coordinate your health care services
- Serve as an advocate for your health care needs
- Give you educational materials and information about community-based resources, and
- Promote a healthy lifestyle

We will help you set positive health care goals and will coach you to reach them. Members may call **1.800.317.2299** for assistance with case management.
Healthy Blue Beginnings
Our maternity support program, Healthy Blue Beginnings, provides information and confidential support before, during and after your pregnancy to help you keep you and your baby healthy. This program is available at no extra cost and is open to all women who are currently pregnant, thinking about becoming pregnant, or have an infant less than one year old. We also offer support to help moms-to-be identify early warning signs of potential problems and special challenges. Members may call 1.800.317.2299 for more information about this program or to notify us that you are pregnant, so that you can be enrolled in this program.

Continuity of Care
Under special circumstances such as a high-risk pregnancy or life-threatening illness, Blue Cross may allow members to continue receiving healthcare services from a non-network physician or other healthcare practitioner for a specified duration of time. Blue Cross members may request a Continuity of Care form by contacting Customer Service at 1.800.392.4089 or www.bcbsla.com/ogb.

Disease Management
Our disease management program, In Health: Blue Health Services, offers you support in controlling one or more of these five chronic health conditions: coronary artery disease (CAD), heart failure, asthma, diabetes and chronic pulmonary obstructive disease (COPD). Our Health Coaches are here to provide guidance and encouragement as you develop goals and make important behavior changes that will help you to improve your overall health and well-being. To connect with a Health Coach, call us at 1.800.363.9159 and speak with one of our Health Coaches who can get you started on your way to a healthier you.
General and Specialist Care
If you need routine care, call your doctor and plan an office visit.

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

Emergency Care
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 and her unborn child, in serious jeopardy; 2) Serious impairment to bodily function; 3) Serious dysfunction of any bodily organ or part.

Dental Discount Network
Members can take advantage of special discounts on dental services by simply presenting their ID card to a participating provider and immediately receiving significant savings.

To find a discount provider, visit www.bcbsla.com/ogb and under Find Care, click on Louisiana Directory. Next to Step 1, from the drop-down Network menu, choose Discount Dental.

Please note these services are a separate discount program offered at no additional cost. The discount program is not part of the Blue Cross medical plans.

Member ID Card
Blue Cross will issue two membership ID cards per family. Each ID card will list only the employee’s name, but can be used for all covered dependents. Your ID card also includes the following information:

- 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.

Your Right to Appeal
If you or your provider disagree with a clinical decision Blue Cross has made about covered services, you have the right to appeal. You can submit appeals by writing to:

Blue Cross and Blue Shield of Louisiana
Appeal and Grievance Unit
P.O. Box 98045
Baton Rouge, Louisiana 70898-9045

If a member has questions or needs assistance putting the appeal in writing, he or she may call Customer Service at 1.800.392.4089.
My Account
Our members want more ways to manage their health information. That’s why we offer password-protected online tools that allow you to review and manage your healthcare information 24 hours a day, seven days a week.

To register your online account, go to www.bcbsla.com/ogb and click LOG IN for instructions on how to register. If you need help registering or logging in, call the 24-hour support line at 1.800.821.2753.

Your online account tools help you manage your health with access to a summary of your benefits, claims activity, online health records, health education, treatment options, wellness programs and discounts.

Claims Review
See your latest plan activity or search past claims on the Review Claims screen:

- View your claims and the claims of covered dependents under 18.
- Easily see your costs in the highlighted columns.
- Search past claims by date, provider, etc.
- See claims payment status.
- Rate your doctor and write a review of a recent visit.

Online Health Records
Use our free online health records to track your health history and to give new healthcare providers insight into your past care.

Personal Health Record
This free tool is an easy, secure way to keep track of your past conditions and treatments. You can allow the Blue Cross claims system to add your claims information to your record, then update it yourself with family history, allergies, emergency contact information and any other healthcare-related information you might need to access while away from home.

Blue Health Record
Your Blue Health Record provides a quick three-year summary of your medical care, based on claims and organized by episode of care.
Health Education

It’s important to understand your health and stay informed about ways to improve it. That’s why Blue Cross provides an extensive online health encyclopedia, as well as a video library with educational and entertaining videos on a number of health topics.

We also offer:

- An online **Personal Health Assessment** (PHA) tool that allows you to learn your health risks and prioritize an action plan to address them.
- **Preventive Medicine Guidelines** for specific ages and gender.
- **Health condition guides** for a selection of common illnesses and injuries, such as asthma, diabetes, heart disease, joint replacement, mental health, pain management and more.
- Interactive **self-care workbooks** on asthma, diabetes, COPD, heart disease and heart failure that will help you learn more and track your care.

Social Media

If you like to get health information online and interact with others, check out our online communities for peer support and advice.

My Blue Community

My Blue Community is a health and wellness community composed of members from Blues plans all over the country. You can have discussions with a supportive network of healthy-minded members just like you.

- Join one of thousands of conversations or start a new one.
- Browse message boards and access a wealth of information.
- Connect with healthy-minded people from all across the country.
- Get advice on cooking healthy meals, support for losing weight, tips for better workouts, ideas for better parenting and more.
- Discover support for achieving health and wellness goals.

Facebook

If you follow Facebook and Twitter, check out Blue Cross’ accounts on those services. On our Facebook page (/bluecrossla), you will find daily health tips and news stories of interest to our membership. Our Twitter feed (@bcbsla) will provide you with breaking news stories about health and healthcare.

This is just the tip of the iceberg when you visit www.bcbsla.com/ogb and log in. We are also adding new tools and services all the time—so visit often!

**Security and Confidentiality:** My Blue Community is a website that enables discussions among individual users. This website contains general information and users’ opinions and is intended solely as a forum for general information and discussions. It does not contain any medical or healthcare advice that is intended to be used for medical diagnosis or treatment, and does not substitute for medical or other professional advice and services. Always seek the advice of your physician or other qualified healthcare provider regarding any medical condition and before starting any new treatment or following any information that may appear on My Blue Community.
Good health begins with our My Health, My Way wellness program, open to all members at no extra charge. The program includes:

- A Personal Health Assessment (PHA) to help you learn more about your health status and ways to address health risks.
- Interactive tools that let you track your weight, exercise and food intake.
- Fitness and nutrition plans that can be customized for you and your family.
- Online workshops on topics such as back care, nutrition, smoking cessation, stress management and weight management.
- Exclusive access to a national program, Blue 365®, providing discounts and savings on fitness club memberships, nutrition programs and products, financial well-being services, family care services and healthy travel. You can even save on elective procedures for vision and hearing.
- It’s all secure, confidential and at no extra charge to you!

Find out more at www.bcbsla.com/ogb under Benefits > Health & Wellness Tools.

**Louisiana 2 Step**

Louisiana ranks near the highest in the nation in adult obesity and in deaths from diabetes. These are some of the reasons why Blue Cross created the Louisiana 2 Step, a free and fun statewide public health education campaign to encourage all Louisianians to eat right and move more.

The award-winning interactive website at www.Louisiana2Step.com and the fun companion site at www.2Step4Kids.com communicate this message in age-appropriate formats. The 2 Step has tools and information to support your My Health, My Way wellness goals.

These great tools also come in a free app for iPhone users! Just go to your App Store and search for “Louisiana2Step.”

**Security and Confidentiality:** The Personal Health Assessment has been engineered to provide the same level of protection for your confidential health information that online banking and consumer websites offer their clients and account-holders. If you are identified as someone who may benefit from Care Management Services, your information may be shared with medical personnel, and you may be contacted by a Care Management nurse.

The information you provide in the PHA will be used only as permitted by law. This information will not adversely affect your enrollment in your health plan.
Living well means having healthy options every day. That’s why we offer Blue365® to take our members beyond health insurance and give you access to exclusive deals on trusted health and wellness resources—365 days a year. As a Blue Cross member, you enjoy special discounts on many services from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more.

Blue365 is a national program that’s part of every plan, making it easier and more affordable to make healthy choices. After signing up, you’ll receive great health and wellness deals straight to your inbox every week. And it’s easy to register. Just go to www.bcbsla.com/ogb and have your Blue Cross and Blue Shield of Louisiana member ID card handy. Click LOG IN to access your online account, then click Blue365.

Follow the instructions, and you’ll have access to two types of good-for-you deals: standing discounts, which you can redeem any time you like, and exclusive, limited-time offers designed for living well—right in the moment.

**Weekly Deals**

Sign up for no-fuss emails, and you’ll be the first to know about the latest deals from Blue365. You won’t get any spam and you’ll only get one email a week. You can also browse deals anytime on the Blue365 website. Take a look at some past offers in the following categories:

### Health & Wellness

- **Healthways** – One of the most popular deals is Healthways Fitness Your Way, a program that gives you access to a network of 8,000+ gyms nationwide for only $25 per month and a low $25 enrollment fee. Participating Healthways gyms include Snap Fitness®, Curves® and more. Also, you get up to 30% off on more than 40,000 experienced health and well-being specialists, including massage therapists, personal trainers, nutrition counselors, yoga and Pilates instructors and more. Save on vitamins, exercise equipment, aromatherapy, organic products and unique gifts.

- **Fitness** – Blue365 offers other fitness deals as well, including discounts from Reebok, Polar Heart Rate Monitors and Body Media FIT, for example, and savings on other types of health club memberships.

- **Diet/Weight Control** – Savings on programs, products and consultations at Jenny Craig and NutriSystem.

- **Vision Discounts** – With Blue365 our members can receive routine eye exams, frames, lenses, conventional contact lenses and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to more than 30,000 providers nationwide, including optometrists, ophthalmologists and many retail centers. Members can also save 40 to 50 percent off the overall national average price for Lasik surgery through QualSight LASIK and LASIK Plus.
Financial Health

- **Tax Preparation** – Discounts on income tax preparation from H&R Block At Home.
- **Coupons and Savings** – For example, members earn exclusive coupons when you join Costco as a new member and a new healthy grocery coupon each week.

Family Care

- **Programs for Kids** – Savings on kids’ wellness products, such as Brush Buddies and GeoPalz pedometers. Also, get access to child safety and consumer product information.
- **Senior Care** – Discounts on care advisory services and eldercare support from organizations such as SeniorLink and CaringBridge.
- **Long-Term Insurance** – Free guidelines and information.
- **Managing Medicare** – Resources to understand coverage options from Medicare.

Travel

- **Healthy Getaways** – Members can find savings on hotel programs, such as The Fairmont.
- **Travel Tips** – A wealth of online travel tips and resources.

Members can explore all these healthy choices after logging in to My Account at www.bcbsla.com/ogb. Just click My Health, then Discounts.

Discounts for Non-Covered Prescription Drugs

OGB members now have free access to a prescription coupon program that provides discounts on non-covered drugs—that is, medications not covered by your pharmacy benefits. The program is accepted at more than 56,000 pharmacies nationwide. Get more information, including pharmacy locations, by visiting www.bcbsla.com/ogb. Under OGB Find Care, click Non-Covered Drug Discount Program.
**BALANCE BILLING DISCLOSURE**

Blue Cross and Blue Shield of Louisiana (BCBSLA) is required by law to send the notice below to all members of the OGB HMO Health Plan option administered by BCBSLA. Members are required to receive this notice at the time of enrollment and annually. The notice is sent as a reminder to make sure you choose a doctor or hospital in the Preferred Care Provider network when you need health care. By choosing a network provider, you avoid the possibility of having your provider bill you for amounts in addition to applicable copayments, coinsurance, deductibles and non-covered services.

You may search for doctors in the Preferred Care Provider network by going to [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb) and clicking on Louisiana Provider Directory or National Provider Directory. If you have any questions, please call our Customer Service at 1.800.392.4089. Thank you for allowing us the opportunity to serve you.

**BALANCE BILLING DISCLOSURE NOTICE:**

Healthcare Services may be provided to you at the Network Healthcare 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 Copayments, 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](http://www.bcbsla.com) or by calling the Customer Service Telephone Number of your Health Plan 1.800.392.4089.