LOUISIANA BLUE

ANNUAL ENROLLMENT GUIDE

State of Louisiana Employees and Retirees Administered by Blue Cross and Blue Shield of Louisiana (Louisiana Blue)

2026

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Louisiana Blue is proud to serve your healthcare needs.

Louisiana Blue is committed to meeting the challenging demands of healthcare in the 21st century. We work hard every day to bring Louisiana Blue plan members the high level of service you expect and deserve. Founded in 1934, we are Louisiana's oldest and largest health insurance company.

Your Plan Features:

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

Ready to Enroll?

- **LaGov* employee** – Log into LEO and select the My Benefits tab and then Annual Enrollment. ***NOTE:*** *Rehired retirees will need to contact HR for any benefit changes.*
- **Non-LaGov* employee** – Visit the Office of Group Benefits (OGB) online enrollment portal at enroll.groupbenefits.org and select your benefits.
- **Retiree** – Visit the OGB online enrollment portal at enroll.groupbenefits.org and select your benefits. Or complete the paper annual enrollment form or contact OGB.

If you decide not to change your plan for next year, do nothing. You will stay on your current plan in 2026.

**"LaGov" and "Non-LaGov" are agency classifications used by OGB. If you are uncertain about whether your agency is classified as LaGov or Non-LaGov, contact your human resources department.*

Customer Service

www.lablue.com/ogb

(800) 392-4089

ogbhelp@lablue.com

To view the Summary of Benefits and Coverage (SBC), go to www.lablue.com/ogb.

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Provider Network

Louisiana Blue network doctors, hospitals and other healthcare providers have agreed to provide the care you need at the best price.

To find a doctor in a Louisiana Blue network:

1. Go to www.lablue.com/ogb
2. Click (Choose member type) and select the plan you are interested in from the drop down menu.
3. Click Find a Doctor and then Find a Doctor in This Network. To find a provider for Magnolia Local, select:
   - **Find a Community Blue Doctor:** If you live in Ascension, East Baton Rouge, Livingston or West Baton Rouge parishes.
   - **Find a Blue Connect Doctor:** If you live in Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Terrebonne or Vermilion parishes.

Network

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

- You receive the highest level of benefits your health plan has to offer.
- You save money, because the provider has agreed with your health plan upon a discounted rate.
- You won't be billed for the difference between what we pay and what the provider charges for covered services (also known as balance billing – see page 63).
- You will be responsible for your coinsurance, copayments and any deductibles that apply under your plan.

Out-of-Network

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

- You could pay a higher copayment, deductible and/or coinsurance.
- The doctor or hospital could bill you for the difference between what we pay and what they charge (also known as balance billing – see page 57).
- You could receive a penalty or reduction in benefits, depending on your plan.

You may contact Customer Service if you have any trouble finding a network provider or if you have any questions at 1-800-392-4089 from 8 a.m. - 5 p.m, Monday – Friday.

Benefits That Travel

The BlueCard® Program allows OGB members to receive healthcare services while traveling or living in another Blue Plan's service area. You'll have peace of mind knowing you will find the care you need if you get sick or injured on the road. BlueCard links participating healthcare providers with the independent Blue Plans across the country through a single electronic network.

Search for a provider outside of the state of Louisiana under National Provider Directory by visiting www.bcbs.com and selecting Find a Doctor from the drop down menu.

NOTE: *Magnolia Local members do not have access to the BCBS National BlueCard Providers.*

Telehealth

Telehealth or virtual care, is a convenient way to be treated for routine, nonemergency health conditions or to access behavioral health services and other forms of care through an online connection. Members can look for a telehealth provider on our Find Care provider directory at findcare.lablue.com. Telehealth providers have an "Offers Virtual Care" indicator. To learn about your telehealth benefits, call the Customer Service number on your member ID card.

Care Management Programs

Your health is important to us. Our health coaches want to support you in leading a fuller, healthier life. If you have been diagnosed with a serious or long-term health condition, call us to find out how we can help you through our Care Management programs.

Louisiana Blue can offer you the assistance and expertise of nearly 250 in-house clinical professionals – including nurses, dietitians and social health coaches. We can talk with you about your health needs and medical history to find a Care Management program that is right for you.

How Will Health Coaches Help Me?

We will help you work toward your health goals, no matter what the size. Health coaching is personalized, and we will assist you with your unique needs.

Our health coaches will:

- Offer tips to stick to the treatment plan your doctor/healthcare provider made for you
- Share information or educational materials about your health condition
- Work with you on areas where you want to make changes, such as quitting smoking, exercising, eating healthy or getting preventive care
- Connect you with in-network healthcare providers in your area
- Send you preventive and wellness care reminders, sometimes along with your doctor's office

Can you participate in the program?
As an OGB plan member, you can participate in Louisiana Blue Care Management programs if you:

- Are enrolled in an OGB health plan administered by Louisiana Blue;
- Do not have Medicare as primary health coverage; and,
- Have been diagnosed with one or more of these ongoing health conditions:
  - Diabetes
  - Coronary artery disease
  - Heart failure
  - Asthma
  - Chronic obstructive pulmonary disease (COPD)

Call (800) 363-9159 to speak with one of our health coaches, who can help you get started.

Bariatric Surgery Benefit

OGB has a bariatric surgery benefit for state employees and retirees who meet specific criteria. The benefit is limited to 300 surgeries per year. An OGB member must have a BMI equal to or greater than 40 *or* a BMI of equal to or greater than 35 with at least two co-morbidities: hypertension, cardiopulmonary conditions, sleep apnea, diabetes or severe osteoarthritis. There is an authorization process and a waiting period. Learn more in this OGB video at https://youtu.be/-7h6I6P5MpA.

NOTE: *Pelican HSA 775 members do not have a bariatric surgery benefit.*

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 Population Health 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 Louisiana Blue before services can be performed.

See page 62 for a list of services and supplies that must be authorized.

Continuity of Care

Under special circumstances, such as a high-risk pregnancy or life-threatening illness, Louisiana Blue may allow members to continue getting their care from a non-network physician or other healthcare practitioner for a specified length of time. Request a Continuity of Care form by contacting Customer Service at 1-800-392-4089 or download the form from our website at www.lablue.com/ogb.

Mental Health and Substance Use Disorder Benefits

Louisiana Blue has a team of experts to provide behavioral health services. Our team manages the mental health and substance use disorder services that are part of your OGB health plan, including outpatient, inpatient, partial hospitalization and residential treatment for mental health and substance use disorders.

Receiving the Best Care

- **Care Management** – Licensed mental health doctors, nurses and other providers help you find a treatment plan that will work best for you and your dependents.
- **Coordinated Care** – Our behavioral health team works with your health plan to understand your needs and to create treatment programs that will meet those needs.
- **High-Quality Care** – Our behavioral health team studies what care works best and compares results to help make your quality of care even stronger.

Authorizations for Care

Our behavioral health team is responsible for all mental health and substance use disorder care authorizations. Your doctor or provider must check with our behavioral health team before you receive care.

Behavioral Health Network Providers

You can go to the Louisiana Blue behavioral health network of doctors for your care. To find out if your doctor is in your behavioral health network, go to www.lablue.com/ogb and click Choose member type. Select the plan you are interested in from the drop down menu. Click Find a Doctor and then Find a Doctor in This Network.

NOTE: *To find a provider for Magnolia Local, select Find a Community Blue Doctor if you live in Ascension, East Baton Rouge, Livingston or West Baton Rouge parishes. Select Find a Blue Connect Doctor if you live in Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Terrebonne or Vermilion parishes.*

Wellness Resources

Live Better Louisiana

Live Better Louisiana is OGB's game plan for better health. The program gives OGB members resources to help you better monitor your health, understand risk factors and make educated choices that keep you healthier. Louisiana Blue sponsors the program at no extra charge to you.

Live Better Louisiana can also save you money on next year's health insurance premium. Complete a Catapult Health[1] clinic before the end of the program year and you could qualify for a premium credit next year[2]. During this no out-of-pocket cost preventive care visit, learn your health status related to diabetes, heart disease and stroke. Get lab-accurate results in minutes. Review your results with a board-certified nurse practitioner and develop a personal action plan.

To learn more about Live Better Louisiana, visit www.lablue.com/ogb, select your plan and then click the Wellness tab. To sign up for a Catapult clinic near you, go to www.timeconfirm.com/ogb. If you need assistance, you can reach out to Catapult customer support via email at support@catapulthealth.com or call/text at 855-509-1211.

[1]Catapult Health is an independent provider that provides worksite health screenings for Blue Cross and Blue Shield of Louisiana and its subsidiaries.

[2]If you got your premium credit for a prior year, you will need to qualify again for 2027. To complete the checkup, you must be the primary member on an OGB Louisiana Blue policy that is in effect at the time of the checkup. To get the credit, you must be the primary member on an OGB Louisiana Blue policy in 2027.

Quit Smoking

Using proven techniques tested over 25 years, Quit With Us LA has helped millions of people and it can help you too. Call 1-800-QUIT NOW or visit quitwithusla.org to enroll.

Blue365®

Blue365® helps you save on a healthier lifestyle with deals on gym memberships, healthy eating options, hearing and vision products, family activities, financial health, travel and more.

Examples include:

- Access 10,000+ on-demand digital workouts for $5/month
- Access 20,000+ Gyms & Studios starting at $19/month
- 16%-30% off select fitness gear, including Allbirds, Hey Dude, Skechers and Crocs
- 10-40% off Davis Vision products
- Exclusive savings from top hearing aid manufacturers
- Up to 50% off dental services
- Up to 20% off pet health insurance

Go to www.blue365deals.com/lablue to get started.

Empowering OGB Employees with MyLABlue!

MyLABlue is a new digital experience designed to help our members take control of their Louisiana Blue health insurance, simply and securely.

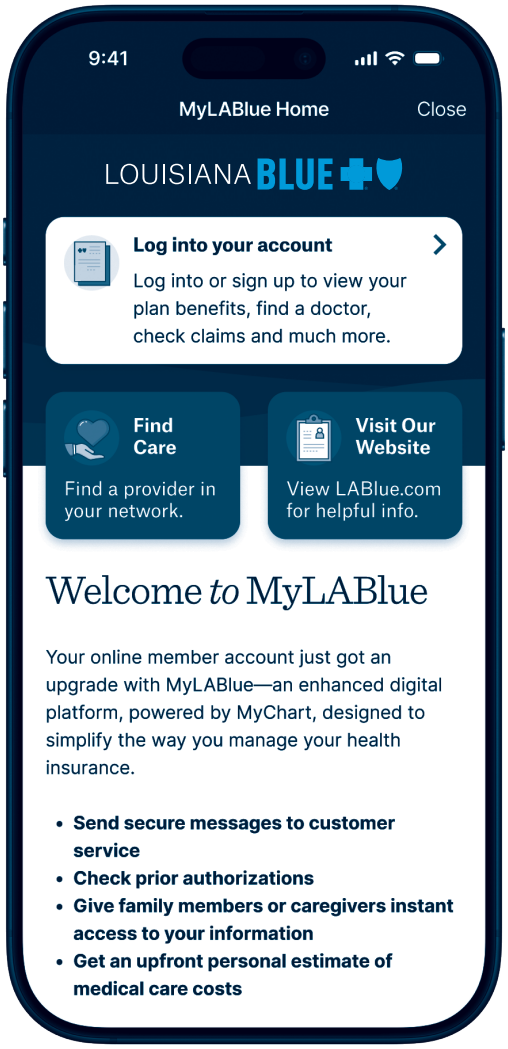
MyLABlue is powered by Epic's MyChart and gives you the tools you need to stay informed, connected and in charge of your health coverage — whether online at lablue.com, through the MyLABlue app or via your MyChart account.

With MyLABlue, members will be able to:

- **Track your health insurance activity** — View claims, benefits and deductibles in one place
- **Find providers** — Search in-network doctors and download your digital ID card
- **Estimate costs** — Get personalized upfront estimates for medical care
- **Connect with support** — Message securely with Louisiana Blue representatives
- **Check prior authorizations** — See where certain requests stand and what's next
- **Share access** — Allow family or caregivers to view your health info
- **Stay healthy** — Sync health and fitness data including from Apple Health

MyLABlue makes it easier for members to manage their care — anytime, anywhere.

Go to www.lablue.com to register yiour online account.



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PELICAN HRA1000

Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/26 - 12/31/26

Deductible per Benefit Period

	Network	Non-Network
Individual	$2,000	$4,000
Family	$4,000	$8,000

NOTE about your deductible: *Deductibles for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the deductible amount for network providers* ***will not*** *count toward the deductible amount for non-network providers.*

Eligible expenses for services of non-network providers that apply to the deductible amounts for non-network providers ***will not*** *count toward the deductible amount for network providers.*

Coinsurance

	Plan Pays	You Pay
Network	80%	20%
Non-Network	60%	40%

What Is Coinsurance?
This plan includes a cost-sharing arrangement called coinsurance, which means your plan pays the majority of your covered medical expenses, and you pay a small percentage.

OGB determines out-of-pocket maximums for its plan members by primary plan payer — OGB or Medicare. Maximum out-of-pocket amount includes all eligible deductibles, coinsurance amounts and copayments.

Out-of-Pocket Maximum

OGB is primary payer for all plan members:	In-Network	Non-Network
Individual	$5,000	$10,000
Family Per member within a family	$10,000 $ 6,850	$20,000 N/A

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	$3,000	$10,000
Family – *Medicare paying primary for 1* Per member within a family	$8,000 $ 6,850	$20,000 N/A
Family – *Medicare paying primary for 2*	$6,000	$20,000
Family – *Medicare paying primary for 3*	$4,000	$20,000
Prescription Out-of-Pocket Maximum	$2,000 per participant	

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers ***will not*** *count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers* ***will not*** *count toward the out-of-pocket maximum for network providers.*

After the Per Member Within a Family Out-of-Pocket Amount is met, the plan will pay 100% of the allowable charge for network services for that family member for the remainder of the benefit period. No family member may contribute more than the Per Member Within a Family Out-of-Pocket Amount toward the family out-of-pocket amount.

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	80% - 20%[1]	60% - 40%[1]
Allied Health/Other Office Visits: • Chiropractor • Retail Health Clinic • Nurse Practitioner • Physician's Assistant	80% - 20%[1]	60% - 40%[1]
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20%[1]	60% - 40%[1]
Ambulance Services - Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	80% - 20%[1]	80% - 20%[1]
Ambulance Services - Air (Non-emergency requires prior authorization[2])	80% - 20%[1]	80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20%[1]	60%-40%[1]
Bariatric Surgery No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.	$2,500 Copayment[2,3] for Facility Services 90% - 10%[2,3] for Professional Services 80% - 20%[2,3] for Preoperative and Postoperative Medical Services	No Coverage

[1]Subject to plan year deductible | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary | [3]Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan)	100% - 0%	60% - 40%[1]
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	80% - 20%[1,2,3]	60% - 40%[1,2,3]
Chemotherapy/Radiation Therapy	80% - 20%[1]	60% - 40%[1]
Diabetes Treatment	80% - 20%[1]	60% - 40%[1]
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities.	80% - 20%[1]	Not covered
Dialysis	80% - 20%[1]	60% - 40%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2]	60% - 40%[1,2]
Emergency Room (facility charge)	80% - 20%[1]	80% - 20%[1]
Emergency Medical Services (non-facility charge)	80% - 20%[1]	80% - 20%[1]
Eyeglass frames and one pair of eyeglass lenses or one pair of contact lenses (purchased within six months following cataract surgery).	Eyeglass frames limited to a maximum benefit of $50[1,3]	Not covered
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	80% - 20%[1,3]	Not covered
High-Tech Imaging – Outpatient (CT Scans, MRI/ MRA, nuclear cardiology, PET scans)	80% - 20%[1,2]	60% - 40%[1,2]
Home Health Care (limit of 60 visits per Plan Year)	80% - 20%[1,2]	60% - 40%[1,2]
Hospice Care (limit of 180 days per Plan Year)	80% - 20%[1,2]	60% - 40%[1,2]
Injections Received in a Physician's Office (when no other health services are received)	80% - 20%[1]	60% - 40%[1]
Inpatient Hospital Admission (all Inpatient Hospital services included)	80% - 20%[1,2]	60% - 40%[1,2]
Inpatient and Outpatient Professional Services	80% - 20%[1]	60% - 40%[1]
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	100% - 0%

[1]Subject to plan year deductible | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary | [3]Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Mastectomy Bras (limited to three per Plan Year)	80% - 20%[1]	60% - 40%[1]
Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient programs	80% - 20%[1,2]	60% - 40%[1,2]
Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs)	80% - 20%[1]	60% - 40%[1]
Newborn – Sick, services excluding facility	80% - 20%[1]	60% - 40%[1]
Newborn – Sick, facility	80% - 20%[1,2]	60% - 40%[1,2]
Oral Surgery	80% - 20%[1,2]	60% - 40%[1,2]
Pregnancy Care – Physician Services	80% - 20%[1]	60% - 40%[1]
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care article in the Benefit Plan.)	100% - 0%[3]	100% - 0%
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational[2] (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) Visit limits do not apply when services are provided for Autism Spectrum Disorders.	80% - 20%[1]	60% - 40%[1]
Skilled Nursing Facility (limit of 90 days per Plan Year)	80% - 20%[1,2]	60% - 40%[1,2]
Sonograms and Ultrasounds – Outpatient	80% - 20%[1]	60% - 40%[1]
Transplants – Organ, Tissue and Bone Marrow	80% - 20%[1,2]	Not Covered
Urgent Care Center	80% - 20%[1]	60% - 40%[1]
Vision Care (Non-Routine) Exam	80% - 20%[1]	60% - 40%[1]
X-Ray (Low-Tech Imaging) and Laboratory Services	80% - 20%[1]	60% - 40%[1]

[1]Subject to plan year deductible | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary | [3]Age and/or time restrictions apply

Your Prescription Drug Program

OGB's contracted pharmacy benefits manager uses a formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market.

You will pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

See OGB's annual enrollment website for more information about your prescription drug coverage.

What is a Health Reimbursement Arrangement (HRA)?

The Pelican HRA1000 is a consumer-driven health plan with a Health Reimbursement Arrangement (HRA). This plan has low premiums and an employer-funded HRA, which reimburses you for qualified medical expenses.

With the Pelican HRA1000, your employer contributes $1,000 annually for employee-only plans and $2,000 annually for family plans. The HRA pays for 100% of covered medical expenses from any healthcare provider until the fund is used up. The HRA also counts toward your total deductible for the year. HRA funds you do not spend will roll over each year up to the in-network out-of-pocket maximum as long as you remain enrolled in the Pelican HRA1000 Plan.

HRA vs. HSA (Health Savings Account): What's the difference?

	Health Reimbursement Arrangement (HRA)	Health Savings Account (HSA)
Funding	• Employer funds HRA. Only employers may contribute. • Funds stay with the employer if employee leaves an OGB-participating employer. • Contributions are not taxable.	• Both employer and employee may fund HSA. • Funds go with the employee if he/she leaves an OGB-participating employer. • Contributions are made on a pre-tax basis.
Flexibility	• Employer selects maximum contribution. • Must be paired with the Pelican HRA1000. • Contributions are the same for each employee. • May be used with a General-Purpose FSA.	• IRS determines maximum contribution. • Must be paired with the Pelican HSA775. • Contributions are determined by employee and employer. • May be used only with a Limited-Purpose FSA.
Simplicity	• HRA claims are processed by the claims administrator.	• Employee manages account and submits expenses to the HSA trustee for reimbursement.

PELICAN HSA775

Schedule of Benefits

Active employees
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/26 - 12/31/26

Deductible per Benefit Period

	Network	Non-Network
Individual	$2,000	$4,000
Family	$4,000	$8,000

NOTE about your deductible: *Deductibles for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the deductible amount for network providers* ***will not*** *count toward the deductible amount for non-network providers.*

Eligible expenses for services of non-network providers that apply to the deductible amounts for non-network providers ***will not*** *count toward the deductible amount for network providers.*

Coinsurance

	Plan Pays	You Pay
Network	80%	20%
Non-Network	60%	40%

What Is Coinsurance?

This plan includes a cost-sharing arrangement called coinsurance, which means your plan pays the majority of your covered medical expenses, and you pay a small percentage.

Out-of-Pocket Maximum

	Network	Non-Network
Individual	$5,000	$10,000
Family	$10,000	$20,000
Per member within a family	$6,650	N/A

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers ***will not*** *count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers* ***will not*** *count toward the out-of-pocket maximum for network providers.*

After the Per Member Within a Family Out-of-Pocket Amount is met, the plan will pay 100% of the allowable charge for network services for that family member for the remainder of the benefit period. No family member may contribute more than the Per Member Within a Family Out-of-Pocket Amount toward the family out-of-pocket amount.

All members:

When you have paid the maximum out-of-pocket amounts shown above, this plan will pay 100% of the allowable charge toward eligible expenses for the remainder of the plan year. The allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

Eligible expenses are paid according to a fee schedule of maximum allowable charges—not billed charges. All eligible expenses are determined in accordance with plan limitations and exclusions.

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	80% - 20%[1]	60% - 40%[1]
Allied Health/Other Office Visits: • Chiropractor • Retail Health Clinic • Nurse Practitioner • Physician's Assistant	80% - 20%[1]	60% - 40%[1]
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20%[1]	60% - 40%[1]
Ambulance Services - Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	80% - 20%[1]	80% - 20%[1]
Ambulance Services - Air (Non-emergency requires prior authorization[2])	80% - 20%[1]	80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20%[1]	60% - 40%[1]
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan)	100% - 0%	60% - 40%[1]
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	80% - 20%[1,2,3]	60% - 40%[1,2,3]
Chemotherapy/Radiation Therapy	80% - 20%[1]	60% - 40%[1]
Diabetes Treatment	80% - 20%[1]	60% - 40%[1]

[1]Subject to plan year deductible | [2]Pre-authorization required | [3]Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	80% - 20%[1]	Not covered
Dialysis	80% - 20%[1]	60% - 40%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2]	60% - 40%[1,2]
Emergency Room (facility charge)	80% - 20%[1]	80% - 20%[1]
Emergency Medical Services (non-facility charge)	80% - 20%[1]	80% - 20%[1]
Eyeglass frames and one pair of eyeglass lenses or one pair of contact lenses (purchased within six months following cataract surgery)	Eyeglass frames limited to a maximum benefit of $50[1,3]	Not covered
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	80% - 20%[1,3]	Not covered
High-Tech Imaging – Outpatient (CT Scans, MRI/MRA, nuclear cardiology, PET scans)	80% - 20%[1,2]	60% - 40%[1,2]
Home Health Care (limit of 60 visits per Plan Year)	80% - 20%[1,2]	60% - 40%[1,2]
Hospice Care (limit of 180 days per Plan Year)	80% - 20%[1,2]	60% - 40%[1,2]
Injections Received in a Physician's Office (when no other health services are received)	80% - 20%[1]	60% - 40%[1]
Inpatient Hospital Admission (all Inpatient Hospital services included)	80% - 20%[1,2]	60% - 40%[1,2]
Inpatient and Outpatient Professional Services	80% - 20%[1]	60% - 40%[1]
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	100% - 0%
Mastectomy Bras (limited to three per Plan Year)	80% - 20%[1]	60% - 40%[1]
Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient treatment	80% - 20%[1,2]	60% - 40%[1,2]
Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs)	80% - 20%[1]	60% - 40%[1]

[1]Subject to plan year deductible | [2]Pre-authorization required | [3]Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Newborn – Sick, services excluding facility	80% - 20%[1]	60% - 40%[1]
Newborn – Sick, facility	80% - 20%[1,2]	60% - 40%[1,2]
Oral Surgery	80% - 20%[1,2]	60% - 40%[1,2]
Pregnancy Care – Physician Services	80% - 20%[1]	60% - 40%[1]
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care article in the Benefit Plan.)	100% - 0%[3]	100% - 0%
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational[2] (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) Visit limits do not apply when services are provided for Autism Spectrum Disorders.	80% - 20%[1]	60% - 40%[1]
Skilled Nursing Facility (limit of 90 days per Plan Year)	80% - 20%[1,2]	60% - 40%[1,2]
Sonograms and Ultrasounds – Outpatient	80% - 20%[1]	60% - 40%[1]
Transplants – Organ, Tissue and Bone Marrow	80% - 20%[1,2]	Not Covered
Urgent Care Center	80% - 20%[1]	60% - 40%[1]
Vision Care (Non-Routine) Exam	80% - 20%[1]	60% - 40%[1]
X-Ray (Low-Tech Imaging) and Laboratory Services	80% - 20%[1]	60% - 40%[1]

[1]Subject to plan year deductible | [2]Pre-authorization required | [3]Age and/or time restrictions apply

Your Prescription Drug Program

OGB's contracted pharmacy benefits manager uses a formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market.

You will pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

See OGB's annual enrollment website for more information about your prescription drug coverage.

What Is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a savings account you can use with Pelican HSA775, a consumer-driven health plan. The HSA allows you to save money tax-free for medical and pharmacy expenses. It can help you meet your deductible, pay any applicable copayments and help you save for future healthcare expenses.

If you choose the HSA option, the state will contribute $200 at the start of the plan year to help jump-start your savings. The state will then match the tax-free contributions you make through payroll deductions up to an additional $575 per plan year. The state may contribute a total of $775 per plan year, but you can contribute beyond that; for the 2026 calendar year, the U.S. Internal Revenue Service (IRS) allows total tax-free HSA contributions up to $4,400* for employee only coverage and $8,750 for family coverage—plus an additional $1,000 if you are age 55 or older.

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. Your money can remain in your HSA and earn tax-free interest from year to year.

If you wish to apply for an HSA, you should enroll through the online annual enrollment portal or through your human resources office. You SHOULD NOT submit applications directly to Health Equity.**

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

**These amounts were announced by the IRS for 2026. They may change annually and are subject to additional IRS rules. Check with your tax advisor. Information can also be found at www.irs.gov.*

***Health Equity, which owns MySmart$aver, is an independent company that provides HSA options to customers of Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.*

MAGNOLIA LOCAL PLUS

Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/26 - 12/31/26

Deductible per Benefit Period

Active Employees and Retirees (retirement date ON or AFTER 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	$400	No coverage
Individual + 1 dependent	$800	No coverage
Individual + 2 or more dependents	$1,200	No coverage

Retirees (retirement date PRIOR to 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	$0	No coverage
Individual + 1 dependent	$0	No coverage
Individual + 2 or more dependents	$0	No coverage

OGB determines out-of-pocket maximums for its plan members by primary plan payer — OGB or Medicare. Maximum out-of-pocket amount includes all eligible deductibles, coinsurance amounts and copayments.

Out-of-Pocket Maximum

OGB is primary payer for all plan members:

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

	In-Network	Non-Network
Individual	$3,500	No coverage
Individual + 1 dependent	$6,000	No coverage
Individual + 2 or more dependents	$8,500	No coverage

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

Retirees with a retirement date PRIOR to March 1, 2015

	In-Network	Non-Network
Individual	$2,000	No coverage
Individual + 1 dependent	$3,000	No coverage
Individual + 2 or more dependents	$4,000	No coverage

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	$1,500	No coverage
Individual + 1 dependent *Medicare paying primary for 1*	$4,000	No coverage
Individual + 1 dependent *Medicare paying primary for 2*	$2,000	No coverage
Individual + 2 or more dependents *Medicare paying primary for 1*	$6,500	No coverage
Individual + 2 or more dependents *Medicare paying primary for 2*	$4,000	No coverage
Individual + 2 or more dependents *Medicare paying primary for 3*	$2,500	No coverage
Prescription Out-of-Pocket Maximum	$2,000 per participant	

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Retirees with a retirement date PRIOR to March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	$500	No coverage
Individual + 1 dependent *Medicare paying primary for 1*	$1,500	No coverage
Individual + 1 dependent *Medicare paying primary for 2*	$0	No coverage
Individual + 2 or more dependents *Medicare paying primary for 1*	$2,500	No coverage
Individual + 2 or more dependents *Medicare paying primary for 2*	$1,000	No coverage
Individual + 2 or more dependents *Medicare paying primary for 3*	$0	No coverage
Prescription Out-of-Pocket Maximum	$1,500 per participant	

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

All Members:

When the out-of-pocket maximum, 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.

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges, not billed charges. An allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

NOTE: *Some retirees prior to March 1, 2015, have a medical out-of-pocket max of $0. Those retirees may have different copayments and/or coinsurance than shown below.*

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	$25 Copayment per Visit	No Coverage
Allied Health/Other Office Visits: • Chiropractor • Federally Funded Qualified Rural Health Clinic • Nurse Practitioner • Retail Health Clinic • Physician's Assistant	$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietician • Sleep Disorder Clinic	$50 Copayment per Visit	No Coverage
Ambulance Services - Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	$50 Copayment for: Emergency In-state Emergency Out-of-state Non-Emergency	$50 Copayment for: Emergency In-state Emergency Out-of-state (No coverage for Non-Emergency)
Ambulance Services - Air (Non-emergency requires prior authorization[2])	$250 Copayment	$250 Copayment (Emergency Medical Transportation Only)
Ambulatory Surgical Center and Outpatient Surgical Facility	$100 Copayment	No Coverage

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Bariatric Surgery No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.	$2,500 Copayment[2,3] for Facility Services 90% - 10%[2,3] for Professional Services 80% - 20%[2,3] for Preoperative and Postoperative Medical Services	No Coverage
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan)	100% - 0%	No Coverage
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	$25/$50 Copayment per day depending on Provider type[2,3] $50 Copayment – Outpatient Facility[2,3]	No Coverage
Chemotherapy/Radiation Therapy	Office – $25 Copayment per Visit Outpatient Facility 100% - 0%[1]	No Coverage
Diabetes Treatment	80% - 20%[1]	No Coverage
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	$25 Copayment	No Coverage
Dialysis	100% - 0%[1]	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year	No Coverage
Emergency Room (facility charge)	$200 Copayment; Waived if Admitted to the Same Facility	
Emergency Medical Services (non-facility charge)	100% - 0%[1]	100% - 0%[1]

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1,3]	No Coverage
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	80% - 20%[1,3]	No Coverage
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	$50 Copayment[2]	No Coverage
Home Health Care (limit of 60 visits per Plan Year)	100% - 0%[1,2]	No Coverage
Hospice Care (limit of 180 Days per Plan Year)	100% - 0%[1,2]	No Coverage
Injections Received in a Physician's Office (when no other health service is received)	100% - 0%[1]	No Coverage
Inpatient Hospital Admission (all Inpatient Hospital services included)	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for which a Copayment is not applicable	100% - 0%[1]	No Coverage
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	No Coverage
Mastectomy Bras (limited to three per Plan Year)	80% - 20%[1] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year	No Coverage
Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient programs	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Mental Health/Substance Use Disorder – Office visits and outpatient treatment other than intensive outpatient programs	$25 Copayment per Visit	No Coverage

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Newborn – Sick, services excluding facility	100% - 0%[1]	No Coverage
Newborn – Sick, facility	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Oral Surgery	100% - 0%[1,2]	No Coverage
Pregnancy Care – Physician Services	$90 Copayment per pregnancy	No Coverage
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care article in the Benefit Plan.)	100% - 0%[3]	No Coverage
Rehabilitation Services – Outpatient: • Physical/Occupational (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) • Speech Visit limits do not apply when services are provided for Autism Spectrum Disorders	$25 Copayment per Visit	No Coverage
Skilled Nursing Facility (limit of 90 days per Plan Year)	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Sonograms and Ultrasounds – Outpatient	$50 Copayment	No Coverage
Transplants – Organ, Tissue and Bone Marrow	100% - 0%[1,2] after deductible	No Coverage
Urgent Care Center	$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	$25/$50 Copayment depending on Provider type	No Coverage
X-Ray (Low-Tech Imaging) and Laboratory Services	Office or Independent Lab 100% - 0% Hospital Facility 100% - 0%[1]	No Coverage

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Your Prescription Drug Program

OGB's contracted pharmacy benefits manager uses a formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market.

You will pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

See OGB's annual enrollment website for more information about your prescription drug coverage.

MAGNOLIA OPEN ACCESS

Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/26 - 12/31/26
- **Eligibility:** The plan administrator assigns eligibility to all plan members.

Deductible per Benefit Period

Active Employees and Retirees (retirement date ON or AFTER 03/01/15)

	Network	Non-Network
Individual +2 or more dependents Medicare paying primary for 3	$2,500	$2,700

Active Employees and Retirees (retirement date ON or AFTER 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	$900	$900
Individual + 1 dependent	$1,800	$1,800
Individual + 2 or more dependents	$2,700	$2,700

Retirees (retirement date PRIOR to 03/01/15) (with and without Medicare)

	Network and Non-Network
Individual	$300
Individual + 1 dependent	$600
Individual + 2 or more dependents	$900

NOTE about your deductible for Active and Retirees on or after 03/01/15: *Deductibles for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the deductible amount for network providers* ***will not*** *count toward the deductible amount for non-network providers.*

Eligible expenses for services of non-network providers that apply to the deductible amounts for non-network providers ***will not*** *count toward the deductible amount for network providers.*

NOTE about your deductible for retirees prior to 03/01/15: *The deductible amount is a single amount that includes eligible charges incurred from all providers combined.*

To the extent required by federal law, cost sharing for Non-Emergency Services performed by Non-Network Providers at Network facilities will be at the Network level and based on the recognized amount.

OGB determines out-of-pocket maximums for its plan members by primary plan payer — OGB or Medicare. Maximum out-of-pocket amount includes all eligible deductibles, coinsurance amounts and copayments.

Out-of-Pocket Maximum

OGB is primary payer for all plan members:

Active employees and retirees with a retirement date ON or AFTER March 1, 2025

	In-Network	Non-Network
Individual	$3,500	$4,700
Individual + 1 dependent	$6,000	$8,500
Individual + 2 or more dependents	$8,500	$12,250

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

Retirees with a retirement date PRIOR to March 1, 2015

	In-Network	Non-Network
Individual	$2,300	$4,300
Individual + 1 dependent	$3,600	$7,600
Individual + 2 or more dependents	$4,900	$10,900

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers ***will not*** *count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers will not count toward the out-of-pocket maximum for network providers.*

NOTE about your out-of-pocket maximum for retirees prior to 03/01/15: *Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Amount for Network Providers will accrue to the Out-of-Pocket Amount for Non-Network Providers. Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Amount for Non-Network Providers will accrue to the Out-of-Pocket Amount for Network Providers.*

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	$1,500	$4,700
Individual + 1 dependent *Medicare paying primary for 1*	$4,000	$8,500
Individual + 1 dependent *Medicare paying primary for 2*	$2,000	$8,500
Individual + 2 or more dependents *Medicare paying primary for 1*	$6,500	$12,250
Individual + 2 or more dependents *Medicare paying primary for 2*	$4,500	$12,250
Individual + 2 or more dependents *Medicare paying primary for 3*	$2,500	$12,250
Prescription Out-of-Pocket Maximum	$2,000 per participant	

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers ***will not*** *count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers* ***will not*** *count toward the out-of-pocket maximum for network providers.*

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Retirees with a retirement date PRIOR to March 1, 2015, WITHOUT Medicare

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual + 1 dependent *Medicare paying primary for 1*	$1,600	$7,600
Individual + 2 or more dependents *Medicare paying primary for 1*	$2,900	$10,900
Individual + 2 or more dependents *Medicare paying primary for 2*	$900	$10,900
Individual + 2 or more dependents *Medicare paying primary for 3*	$0	$10,900
Prescription Out-of-Pocket Maximum	$2,000 per participant	

NOTE about out-of-pocket maximum: *here may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers ***will not*** *count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers* ***will not*** *count toward the out-of-pocket maximum for network providers.*

*N****OTE about your out-of-pocket maximum for retirees prior to 03/01/15:*** *Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Amount for Network Providers will accrue to the Out-of-Pocket Amount for Non-Network Providers. Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Amount for Non-Network Providers will accrue to the Out-of-Pocket Amount for Network Providers.*

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Retirees with a retirement date PRIOR to March 1, 2015, WITH Medicare

Medical Out-of-Pocket Maximum	In-Network and Non-Network
Individual	$1,300
Individual + 1 dependent *Medicare paying primary for 1*	$3,600
Individual + 1 dependent *Medicare paying primary for 2*	$1,600
Individual + 2 or more dependents *Medicare paying primary for 1*	$5,900
Individual + 2 or more dependents *Medicare paying primary for 2*	$3,900
Individual + 2 or more dependents *Medicare paying primary for 3*	$1,900
Prescription Out-of-Pocket Maximum	$2,000 per participant

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers will not count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of anon- network provider that apply to the out-of-pocket maximum for non-network providers will not count toward the out-of-pocket maximum for network providers.

NOTE about your out-of-pocket maximum for retirees prior to 03/01/15: *The out-of-pocket maximum amount is a single amount that includes eligible charges incurred from all providers combined.*

All members:

When the out-of-pocket maximums, as shown above, have been satisfed, this plan will pay 100% of the allowable charge toward eligible expenses for the remainder of the plan year. The allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

Eligible expenses are reimbursed according to a fee schedule of maximum allowable charges, not billed charges. All eligible expenses are determined in accordance with plan limitations and exclusions.

NOTE: *Some retirees prior to March 1, 2015, have a medical out-of-pocket max of $0. Those retirees may have different copayments and/or coinsurance than shown below.*

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Allied Health/Other Office Visits: • Chiropractor • Nurse Practitioner • Osteopath • Physician's Assistant • Retail Health Clinic	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Specialist (Physician) Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Audiologist • Registered Dietician • Sleep Disorder Clinic • Optometrist	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulance Services – Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	90% - 10%[1]	90%-10%[1] (Emergency In-state) 70%-30%[1] (Emergency Out-of-state) 70%-30%[1] (Non-Emergency)	80% - 20%[1]
Ambulance Services – Air (Non-emergency requires prior authorization[2])	90% - 10%[1]	90% - 10%[1]	80% - 20%[1]

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Ambulatory Surgical Center and Outpatient Surgical Facility	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Bariatric Surgery No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.	$2,500 Copayment[2,3] for Facility Services 90% - 10%[2,3] for Professional Services 80% - 20%[2,3] for Preoperative and Postoperative Medical Services	No Coverage	Network Providers $2,500 Copayment[2,3] for Facility Services 90% - 10%[2,3] for Professional Services 80% - 20%[2,3] for Preoperative and Postoperative Medical Services Non-Network Providers No Coverage
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	70% - 30%[1]	Network Providers 100% - 0% Non-Network Providers 80% - 20%[1]
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	90% - 10%[1,2,3]	70% - 30%[1,2,3]	80% - 20%[1,3]
Chemotherapy/Radiation Therapy	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Diabetes Treatment	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	90% - 10%[1]	Not Covered	80% - 20%[1]
Dialysis	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Emergency Room (facility charge)	$200 Copayment; Waived if Admitted to the Same Facility		
	90% - 10%[1]	90% - 10%[1]	80% - 20%[1]
Emergency Medical Services (non-facility charge)	90% - 10%[1]	90% - 10%[1]	80% - 20%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames - Limited to a Maximum Benefit of $50[1,3]		
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	90% - 10%[1,3]	70% - 30%[1,3]	80% - 20%[1,3]
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Home Health Care (limit of 60 visits per Plan Year)	90% - 10%[1,2]	70% - 30%[1,2]	Not Covered
Hospice Care (limit of 180 days per Plan Year)	80% - 20%[1,2]	70% - 30%[1,2]	Not Covered
Injections Received in a Physician's Office (when no other health service is received)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Inpatient Hospital Admission, all Inpatient Hospital services included	Per day copayment: $0 Day maximum: Not Applicable Coinsurance: 90% - 10%[1,2]	Per day copayment: $50 Day maximum: 5 Days Coinsurance: 70% - 30%[1,2]	Per day copayment: $0 Day maximum: Not Applicable Coinsurance: 80% - 20%[1]
Inpatient and Outpatient Professional Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	100% - 0%	100% - 0%
Mastectomy Bras (limited to three per Plan Year)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Mental Health/Substance Use Disorder - Inpatient treatment and intensive outpatient treatment	Per day copayment: $0 Day maximum: Not Applicable Coinsurance: 90% - 10%[1,2]	Per day copayment: $50 Day maximum: 5 Days Coinsurance: 70% - 30%[1,2]	Per day copayment: $0 Day maximum: Not Applicable Coinsurance: 80% - 20%[1]
Mental Health/Substance Use Disorder – Office and outpatient treatment (other than intensive outpatient programs)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn – Sick, services excluding facility	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn – Sick, facility	Per day copayment: $0 Day maximum: Not Applicable Coinsurance: 90% - 10%[1,2]	Per day copayment: $50 Day maximum: 5 Days Coinsurance: 70% - 30%[1,2]	Per day copayment: $0 Day maximum: Not Applicable Coinsurance: 80% - 20%[1]
Oral Surgery	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Pregnancy Care – Physician Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan.)	100% - 0%[3]	70% - 30%[1,3]	Network Providers 100% - 0%[3] Non-Network Providers 80% - 20%[1,3]

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Rehabilitation Services – Outpatient: • Physical/Occupational (limit of 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) • Speech (Visit limits do not apply when services are provided for Autism Spectrum Disorders)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Skilled Nursing Facility (limit of 90 days per Plan Year)	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Sonograms and Ultrasounds - Outpatient	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Transplants - Organ, Tissue and Bone Marrow	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Urgent Care Center	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Vision Care (Non-Routine) Exam	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
X-Ray (Low-Tech Imaging) and Laboratory Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Your Prescription Drug Program

OGB's contracted pharmacy benefits manager uses a formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market.

You will pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

See OGB's annual enrollment website for more information about your prescription drug coverage.

MAGNOLIA LOCAL

Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/26 - 12/31/26

About the Network

Community Blue and Blue Connect networks in Baton Rouge, Shreveport, New Orleans and Lafayette areas are available for OGB members.

This plan is a limited provider in-network only plan for members who live in specific coverage areas. Out-of-network care is provided only in emergencies. Go to www.lablue.com/ogb, select Magnolia Local, then Find a Doctor and select either Community Blue or Blue Connect to see providers in each network.

Community Blue

A select, local network designed for members who live in the parishes of:

- Ascension
- East Baton Rouge
- Livingston
- West Baton Rouge

Blue Connect

A select, local network designed for members who live in the parishes of:

- Acadia
- Bossier
- Caddo
- Evangeline
- Iberia
- Jefferson
- Lafayette
- Orleans
- Plaquemines
- St. Bernard
- St. Charles
- St. James
- St. John the Baptist
- St. Landry
- St. Martin
- St. Mary
- St. Tammany
- Terrebonne
- Vermilion

Deductible per Benefit Period

Active Employees and Retirees (retirement date ON or AFTER 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	$400	No coverage
Individual + 1 dependent	$800	No coverage
Individual + 2 or more dependents	$1,200	No coverage

Retirees (retirement date PRIOR to 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	$0	No coverage
Individual + 1 dependent	$0	No coverage
Individual + 2 or more dependents	$0	No coverage

OGB determines out-of-pocket maximums for its plan members by primary plan payer — OGB or Medicare. Maximum out-of-pocket amount includes all eligible deductibles, coinsurance amounts and copayments.

Out-of-Pocket Maximum

OGB is primary payer for all plan members:

Active employees and retirees with a retirement date ON or AFTER March 1, 2025

	In-Network	Non-Network
Individual	$2,500	No coverage
Individual + 1 dependent	$5,000	No coverage
Individual + 2 or more dependents	$7,500	No coverage

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

Retirees with a retirement date PRIOR to March 1, 2015

	In-Network	Non-Network
Individual	$1,000	No coverage
Individual + 1 dependent	$2,000	No coverage
Individual + 2 or more dependents	$3,000	No coverage

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	$500	No coverage
Individual + 1 dependent *Medicare paying primary for 1*	$3,000	No coverage
Individual + 1 dependent *Medicare paying primary for 2*	$1,000	No coverage
Individual + 2 or more dependents *Medicare paying primary for 1*	$5,500	No coverage
Individual + 2 or more dependents *Medicare paying primary for 2*	$3,500	No coverage
Individual + 2 or more dependents *Medicare paying primary for 3*	$1,500	No coverage
Prescription Out-of-Pocket Maximum	$2,000 per participant	

NOTE about out-of-pocket maximum: *here may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Retirees with a retirement date PRIOR to March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	$0	No coverage
Individual + 1 dependent *Medicare paying primary for 1*	$1,000	No coverage
Individual + 1 dependent *Medicare paying primary for 2*	$0	No coverage
Individual + 2 or more dependents *Medicare paying primary for 1*	$2,000	No coverage
Individual + 2 or more dependents *Medicare paying primary for 2*	$1,000	No coverage
Individual + 2 or more dependents *Medicare paying primary for 3*	$0	No coverage
Prescription Out-of-Pocket Maximum	$1,000 per participant	

NOTE about out-of-pocket maximum: *There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.*

All Members:
When the out-of-pocket maximum, 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.

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges, not billed charges. An allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

NOTE: *Some retirees prior to March 1, 2015, have a medical out-of-pocket max of $0. Those retirees may have different copayment and/or coinsurance than shown below*

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	$25 Copayment per Visit	No Coverage
Allied Health/Other Office Visits: • Chiropractor • Federally Funded Qualified Rural Health Clinic • Nurse Practitioner • Retail Health Clinic • Physician's Assistant	$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietician • Sleep Disorder Clinic	$50 Copayment per Visit	No Coverage
Ambulance Services - Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	$50 Copayment for: Emergency In-state Emergency Out-of-state Non-Emergency	$50 Copayment for: Emergency In-state Emergency Out-of-state (No coverage for Non-Emergency)
Ambulance Services - Air (Non-emergency requires prior authorization[2])	$250 Copayment	$250 Copayment (Emergency Medical Transportation Only)
Ambulatory Surgical Center and Outpatient Surgical Facility	$100 Copayment	No Coverage

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Bariatric Surgery No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.	$2,500 Copayment[2,3] for Facility Services 90% - 10%[2,3] for Professional Services 80% - 20%[2,3] for Preoperative and Postoperative Medical Services	No Coverage
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan)	100% - 0%	No Coverage
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	$25/$50 Copayment per day depending on Provider type[2,3] $50 Copayment – Outpatient Facility[2,3]	No Coverage
Chemotherapy/Radiation Therapy	Office – $25 Copayment per Visit Outpatient Facility 100% - 0%[1]	No Coverage
Diabetes Treatment	80% - 20%[1]	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	$25 Copayment	No Coverage
Dialysis	100% - 0%[1]	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year	No Coverage
Emergency Room (facility charge)	$200 Copayment; Waived if Admitted to the Same Facility	
Emergency Medical Services (non-facility charge)	100% - 0%[1]	100% - 0%[1]

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1,3]	No Coverage
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	80% - 20%[1,3]	No Coverage
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	$50 Copayment[2]	No Coverage
Home Health Care (limit of 60 Visits per Plan Year)	100% - 0%[1,2]	No Coverage
Hospice Care (limit of 180 Days per Plan Year)	100% - 0%[1,2]	No Coverage
Injections Received in a Physician's Office (when no other service is received)	100% - 0%[1]	No Coverage
Inpatient Hospital Admission (all Inpatient Hospital services included)	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for which a Copayment is not applicable	100% - 0%[1]	No Coverage
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	No Coverage
Mastectomy Bras (limited to three per Plan Year)	80% - 20%[1] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year	No Coverage
Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient programs	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs)	$25 Copayment per Visit	No Coverage
Newborn – Sick, services excluding facility	100% - 0%[1]	No Coverage
Newborn – Sick, facility	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Oral Surgery	100% - 0%[1,2]	No Coverage
Pregnancy Care – Physician Services	$90 Copayment per pregnancy	No Coverage
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care article in the Benefit Plan.)	100% - 0%[3]	No Coverage
Rehabilitation Services – Outpatient: • Physical/Occupational (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) • Speech Visit limits do not apply when services are provided for Autism Spectrum Disorders	$25 Copayment per Visit	No Coverage
Skilled Nursing Facility (limit of 90 days per Plan Year)	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Sonograms and Ultrasounds – Outpatient	$50 Copayment	No Coverage
Transplants – Organ, Tissue and Bone Marrow	100% - 0%[1,2] after deductible	No Coverage

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Urgent Care Center	$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	$25/$50 Copayment depending on Provider type	No Coverage
X-Ray (Low-Tech Imaging) and Laboratory Services	Office or Independent Lab 100% - 0% Hospital Facility 100% - 0%[1]	No Coverage

[1]Subject to plan year deductible, if applicable | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary
[3]Age and/or time restrictions apply

Your Prescription Drug Program

OGB's contracted pharmacy benefits manager uses a formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market.

You will pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

See OGB's annual enrollment website for more information about your prescription drug coverage.

Receive Care in the Best Setting

General and Specialist Care

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

Telehealth Services

Ask you regular healthcare provider if they offer telehealth services. You can also search "telehealth" in the Louisiana Blue provider directory.

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, 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 Solutions through Blue365

OGB members can get up to 50% off on a network of more than 70,000 dentists for just $6 a month. Members can use the program as often as needed, without limits on the number of visits to a participating dentist. There is no waiting and no red tape to join. You will need to register for Blue365 if you have not already. Visit www.lablue.com/ogb to learn more.

Member ID Card

Your ID card includes the following:

- Your member number
- Your in-network and out-of-network deductibles and maximum out-of-pocket amounts
- 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@lablue.com. Get a digital ID card though MyLABlue, Louisiana Blue's digital experience powered by Epic's MyChart.

Your Right to Appeal

If you or your authorized representative disagree with a contractual/benefits denial decision made about covered services, you have the right to appeal. You can submit appeals by writing to:

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

If you or your authorized representative disagree with a clinical decision regarding Not Medically Necessary or an Investigational denial that Louisiana Blue has made, you have the right to appeal. You can submit appeals by fax or in writing to:

Blue Cross and Blue Shield of Louisiana
Medical Appeals Department
P.O. Box 98022
Baton Rouge, LA 70898-9022

Fax: 225-298-1837

If you have a questions or needs assistance putting the appeal in writing, you may call Customer Service at 1-800-392-4089.

Authorization of Inpatient Admissions, Emergency Admissions and Outpatient Services

Louisiana Blue does not accept authorization requests via phone or fax with the exception of transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations, through our Louisiana Blue Authorizations application. This application is available on iLinkBlue (www.lablue.com/ilinkblue), located under the Authorizations menu option.

NOTE: *High-tech imaging & utilizations management program services are authorized through the Carelon MBM Provider Portal by clicking the Carelon Authorizations link.*

Emergency services (life- and limb-threatening emergencies) received outside of the United States (out of country) are covered at the network benefit level. Non-emergency services received outside of the United States (out of country) are covered at the non-network benefit level.

Authorization List

The following services and supplies require authorization prior to the services being rendered or supplies being received.

Inpatient:

- Inpatient Hospital Admissions (except those in connection with childbirth)
- Inpatient Mental Health and Substance Use Disorder Admissions
- Inpatient Organ, Tissue and Bone Marrow Transplant Services
- Inpatient Skilled Nursing Facility Services

Outpatient:

- Air Ambulance – Non-Emergency
- Applied Behavior Analysis
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (Shoulder & Knee)*
- Bariatric Surgery Benefit (Enrollment & Surgery)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cardiac Resynchronization Therapy*
- Cardiac Rhythm Monitors*
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic or Molecular Testing
- Hip Arthroscopy*
- Home Health Care
- Hospice Care
- Hyperbaric
- Implantable Cardioverter Defibrillators*
- Implantable Medical Devices over $2,000, including but not limited to defibrillators
- Intensive Outpatient Programs
- Interventional Spine Pain Management*
- Joint Replacement (Hip, Knee, & Shoulder)*
- Low-Protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (except when performed in a physician's office)
- Orthotic Devices (greater than $300)
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions (such as Coronary Stents and Balloon Angioplasty)*
- Peripheral Revascularization*
- Permanent Implantable Pacemakers*
- PET Scans
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300)
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers
- Resting Transthoracic Echocardiography*
- Sleep Studies (except performed in home)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Urinary Dysfunction or Sexual Dysfunction Resulting from Cancer or Cancer Treatment (Including penile implants)
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy
- Wearable Cardioverter*

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

Balance Billing Disclosure

Blue Cross and Blue Shield of Louisiana is required by law to send the notice below to OGB Plan members when they enroll and once each year they are a member. The notice is provided as a reminder to make sure you choose a doctor or hospital in your provider network when you need healthcare. By choosing a network provider, you avoid the possibility that your provider will bill you for amounts in addition to applicable copayments, coinsurance, deductibles and non-covered services (this is known as "balance billing").

Balance Billing Disclosure Notice:

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES AND NONCOVERED SERVICES.

Specific information about network and non-network facility-based physicians can be found at www.lablue.com or by calling the customer service telephone number of your health plan: 1-800-392-4089.

Notice: your share of the payment for health care services may be based on the agreement between your health plan and your provider. Under certain circumstances, this agreement may allows your provider to bill you for amounts up to the provider's regular billed charges

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

Nondiscrimination Notice

Discrimination Is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@lablue.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps:

1. If you are fully insured through Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.

   Section 1557 Coordinator
   In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
   Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
   Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
   Fax: (225) 298-7240
   Email: Section1557Coordinator@lablue.com

2. If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to **www.lablue.com/checkmyplan**.

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ພິການຫູ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں. ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583. سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کم‌شنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)

LOUISIANA BLUE