Office of Group Benefits
Health Reimbursement Arrangement
For
State of Louisiana Plan Participants

provided by

Louisiana

5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802
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40HR2025 R01/23

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

NOTICE TO ELIGIBLE EMPLOYEES, RETIREES AND DEPENDENTS

This Health Reimbursement Arrangement Plan (the "HRA" or the "Plan") is established by OGB to reimburse you for certain healthcare expenses as described herein. This HRA is integrated with a High Deductible Health Plan specifically designed to work with it. You cannot receive reimbursements from this HRA if you are not enrolled in its integrated High Deductible Health Plan. The HRA will reimburse you for those benefits covered under the High Deductible Health Plan but not reimbursable because they are adjudicated towards the plan's deductible or coinsurance. Healthcare services reimbursable under this HRA may be rendered to you by providers that either participate or not in the High Deductible Health Plan's network. However, to obtain the best advantage of your HRA funds, you should procure your healthcare services from providers that participate in the integrated High Deductible Health Plan's network.

Specific information about Network providers can be found at **http://www.bcbsla.com/ogb** or by calling the customer service telephone number on the back of your identification (ID) card.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

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ARTICLE I. INTRODUCTION

A. Establishment of the Plan

The Office of Group Benefits ("Plan Administrator") hereby establishes this Health Reimbursement Arrangement Plan (the "HRA" or the "Plan") effective January 1, 2015 (the "Effective Date"). This Plan is integrated with a Consumer Driven Health Plan (the "CDHP"), a High Deductible Health Plan specifically designed to work together with this HRA, and shall be administered accordingly. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is intended to permit a Participant to obtain reimbursement of Qualified Medical Expenses on a nontaxable basis from his or her HRA Account.

B. Legal Status

This Plan is intended to be a Health Reimbursement Arrangement (HRA) as defined under Internal Revenue Service (IRS) Notice 2002-45. The Qualified Medical Expenses reimbursed under this HRA are intended to be eligible for exclusion from a Participant's gross income under the Internal Revenue Code (IRC) Section 105(b). This Plan is intended to be an employer-provided medical reimbursement plan under IRC Sections 105 and 106 and regulations issued thereunder, and to satisfy the minimum value method of integration described in IRS Notice 2013-54 and U.S. Department of Labor (DOL) Technical Release (Tech. Rel.) 2013-3, through integration with the CDHP. This Plan and the integrated CDHP shall be interpreted to accomplish these objectives.

ARTICLE II. DEFINITIONS

Accrual – The funds that the Plan Administrator credit to each Participant's HRA Account at the beginning of the Period of Coverage, and are made available for the reimbursement of covered Qualified Medical Expenses.

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

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

B. the Plan Participant's eligibility for coverage under the Benefit Plan;

C. any prospective or retrospective review determination;

D. a Rescission; or

E. a decision involving items and services within the scope of the surprise billing and cost-sharing protection requirements of the No Surprises Act.

Appeal – A written request from a Plan Participant or a Plan Participant's authorized representative to change an Adverse Benefit Determination made by Us.

Available Amount – The dollar amount available in a Plan Participant's HRA Account at any specific point in time for reimbursement of Qualified Medical Expenses, which will be the Accrual credited for the current Period of Coverage, plus any Carryover from a preceding Period of Coverage, reduced by prior reimbursements debited against the account.

Benefits – The Qualified Medical Expenses that are reimbursable under this Plan as described under Article VI.

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

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

Carryover – Funds that are leftover in a Participant's HRA Account at the end of a Period of Coverage after all reimbursements for that Period of Coverage have been made, which are allowed under this Plan to be carried over to the next Period of Coverage.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Compensation – The wages or salary or retiree pension benefits paid to an Employee or Retiree by the Employer.

CDHP – The Consumer Driven Health Plan with which this HRA is integrated. It is a High Deductible Health Plan sponsored by OGB and intended to work together with this HRA.

Covered Person – An Eligible Employee or Retiree, or any of their Dependents eligible for coverage for whom the necessary application forms have been completed, and whom the Plan Administrator has accepted and enrolled into the Plan.

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

A. Spouse–the date of marriage;

B. Child or Children

1. Natural Children –the date of birth

2 Children placed for adoption with the Employee/Retiree:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Electronic Protected Health Information – Has the meaning described in 45 CFR §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

Eligible Employee – An Employee eligible to participate in this HRA, as provided in Section 3.1.

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

Employment Commencement Date – The first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

Enrollment Form – The form provided by the Plan Administrator for the purpose of allowing a person to participate in this Plan.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

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

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

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

C. A decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Plan Participant currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

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

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

B. A decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Plan Participant currently receiving Emergency Medical Services under observation, or receiving Inpatient care.

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

External Appeal – A request for review by an Independent Review Organization (IRO), to change an initial Adverse Benefit Determination made by the Company or to change a final Adverse Benefit Determination rendered on Appeal. An External Appeal is available upon request by the Plan Participant or the Plan Participant's authorized representative for Adverse Benefit Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, Rescission, or for claims for which external review is provided under the No Surprises Act.

FMLA – The Family and Medical Leave Act of 1993, as amended.

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

Health FSA – A health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-5(a) (1).

Highly Compensated Individual - An individual defined under IRC Section 105(h), as amended, as a "highly compensated individual."

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

HRA – A health reimbursement arrangement as defined in IRS Notice 2002-45.

HRA Account(s) – The HRA Accounts described in Article IV (B).

IRC – The Internal Revenue Code of 1986, as amended.

Independent Review Organization (IRO) – An entity, not affiliated with Us, that conducts external reviews of Adverse Benefit Determinations, Recission determinations and No Surprises Act-related decisions. The decision of the IRO is binding on both the Plan Participant and Us, except to the extent the other remedies are available under state of federal law.

Informed Consent - A written document provided along with a written notice to a Plan Participant by a Non-Network Provider that must be executed by a Plan Participant in order for a Non-Network Provider to obtain the Plan Participant's consent to receive medical treatment and service from the Non-Network Provider without the protections provided by the No Surprises Act.

IRS – The U.S. Internal Revenue Service.

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

No Surprises Act (NSA) – A portion of the Consolidated Appropriations Act, 2021 (Public Law 116-260) enacted on December 27, 2020, that establishes patient rights and protections from surprise billing and limits cost sharing under many of the circumstances in which surprise billing occurs most frequently.

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

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

Period of Coverage – The Plan Year, with the following exceptions: (a) for Eligible Employees or Retirees who first become Participants, it shall mean the portion of the Plan Year following the date participation commences; and (b) for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation in the Plan terminates. A different Period of Coverage (e.g., a calendar month) may be established by the Plan Administrator and communicated to Participants.

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

Plan – This HRA as set forth herein and as amended from time to time.

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

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

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

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

Privacy Official – Shall have the meaning described in 45 CFR §164.530(a).

Protected Health Information – Shall have the meaning described in 45 CFR §160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

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

or population of covered persons.

Qualified Medical Expenses – Expenses incurred by a Covered Person for medical items and services that are deductible from the Participant's gross income under IRC Section 213 and IRS Publication 502.

Remote Patient Therapy – A mode of delivering healthcare services that involves the collection of and electronic transmission of biometric data that are analyzed and used to develop, and update a treatment plan related to a chronic and/or acute health condition. Remote Patient Therapy services must be ordered by a licensed Physician, physician assistant, advanced practice registered nurse, or other qualified healthcare Provider who has examined the patient and with whom the patient has an established, documented, and ongoing relationship.

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

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

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

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

USERRA – The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

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

ARTICLE III. SCHEDULE OF ELIGIBILITY

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

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

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

A. Persons to be Covered

1. Employee

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Board and Commission Members

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

f. Legislative Assistants

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

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

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

2. Retiree Coverage-Eligibility

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

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

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

3. Documented Dependent Coverage - Eligibility

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

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

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

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

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

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

4. HIPAA Special Enrollment Events

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

5. Other Special Enrollment or Disenrollment Events

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

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

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

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

7. TRICARE for Life Option for Military Retirees

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

B. Continued Coverage

1. Leave of Absence

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

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

(2) A participating Employee who suffers a service related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the Participant Employer shall continue to pay its portion of the premium until the Employee becomes gainfully employed or is placed on state disability retirement.

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

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

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

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

2. Disability

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

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

3. Surviving Dependents/Spouse

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

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

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

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

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

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

c. Participant Employer/Dependent Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

4. Over-Age Dependents

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

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

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

5. Military Leave

Employees of the National Guard or in the United States military reserves who are called to active military duty and their covered eligible Dependents will have access to continued coverage under OGB's health and life plans subject to submittal of appropriate documentation to OGB.

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

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

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

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

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

C. COBRA

1. Employees

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

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

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

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

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

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

(3) Entitlement to Medicare;

(4) Coverage under a Group Health Plan; or

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

e. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered Spouse and/or covered Dependent Children may elect to continue coverage at his own expense. The elected coverage will be subject to the above stated notification and termination provisions.

2. Surviving Dependents

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

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

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

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

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

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

(3) Entitlement to Medicare;

(4) Coverage under a Group Health Plan; or

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

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

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

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

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

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

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

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

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

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

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

4. Dependent Children

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

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

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

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

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

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

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

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

5. Dependents of COBRA Participants

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

(1) Death of the Employee,

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

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

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

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

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

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

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

(3) Entitlement to Medicare;

(4) Coverage under a Group Health Plan; or

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

6. Disability COBRA

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

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

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

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

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

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

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

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

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

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

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

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

(3) Entitlement to Medicare;

(4) Coverage under a group health plan;

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

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

7. Medicare COBRA

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

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

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

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

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

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

8. Miscellaneous Provisions

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

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

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

D. Change of Classification

1. Adding or Deleting Dependents

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

2. Change in Coverage

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

3. Notification of Change

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

E. Contributions

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

F. Medical Child Support Orders

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

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

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

2. Provides for healthcare coverage for that Dependent Child;

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

4. Relates to Benefits under the Plan; and

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

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

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

G. Termination of Coverage

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

1. The date the Plan terminates;

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

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

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

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

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

ARTICLE IV. METHOD OF FUNDING

A. Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Plan Administrator. Nothing herein will be construed to require the Plan Administrator or any Participant Employer to maintain any fund or to segregate any amount for the benefit of any Covered Person, and no Covered Person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Plan Administrator or any Participant Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

B. Establishment of the Individual HRA Accounts

The Claims Administrator will establish and maintain an HRA Account with respect to each Participant but the Plan Administrator will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions, reimbursements and Available Amounts. HRA Accounts will be kept under the name of the Participant. Claims for any Dependents of the Participant will be paid out of the Participant's HRA Account. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Qualified Medical Expenses.

C. Contributions

All contributions to fund this Plan will come from the Plan Administrator. The Participant will not be allowed to make any kind of contributions to fund this Plan. Under no circumstances will this HRA or the HRA Accounts be funded with Compensations, employee contributions or through an IRC Section 125 Cafeteria Plan, nor will any Compensation reduction or contributions for other employer-sponsored plans or benefits be used or treated as Participant contributions to this Plan.

ARTICLE V. MANAGEMENT OF HRA ACCOUNTS

A. Accruals

The amount of funds that will be credited to each Participant's HRA Account ("Accrual") will depend on the enrollment of that Participant in the integrated CDHP at the moment that the Accrual is credited. Accruals will be as follows:

1. For Employee or Retiree only enrollment - $1,000.00 for the Plan Year.

2. For Employee or Retiree plus any Dependent enrollment ("Family") - $2,000.00 for the Plan Year.

The full amount of the Accruals will be credited at the beginning of each Period of Coverage. If during a Period of Coverage a Participant that started as an Employee or Retiree only upgrades his/her enrollment status to Employee or Retiree plus Family under the special enrollment rules that would allow the Participant to make such an upgrade, the HRA Account will be credited with the difference in Accrual on the effective date of the change.

The Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of covered Qualified Medical Expenses incurred during the Period of Coverage.

B. Nondiscrimination

Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with IRC Section §105(h), as may be determined by the Plan Administrator in its sole discretion.

C. Carryovers from One Period of Coverage to the Next

If any balance remains in the Participant's HRA Account at the end of a Period of Coverage after all reimbursements have been made for that Period of Coverage, such balance shall be carried over to reimburse the Participant for Qualified Medical Expenses incurred during a subsequent Period of Coverage ("Carryover"), as long as the Participant reenrolls in the HRA and its integrated CDHP for such subsequent Period of Coverage. The balance to be carried over from one Period of Coverage to the next will never exceed the integrated CDHP's maximum out of pocket amount for in-network benefits that was effective for the previous CDHP's Plan Year. Any amount over this maximum Carryover will be forfeited at the end of the Period of Coverage.

D. Forfeitures

If an Eligible Employee or Retiree ceases to be a Participant of the HRA and its integrated CDHP for any reason, all Available Amounts in the HRA Account will be forfeited as of the date of termination. Expenses incurred after the Participant's termination date will not be reimbursed. The funds forfeited will not be available for the Participant or his/her Dependents for any future Period of Coverage under the HRA.

E. Reimbursement Procedure

The Claims Administrator will pay reimbursements out of the HRA Account when it adjudicates the claims under the integrated CDHP. The Covered Person will not have to submit a separate claim to receive reimbursements under the HRA. Claims must be submitted to the Claims Administrator under the integrated CDHP's procedures for Covered Persons to have access to the funds in the HRA Account.

Reimbursements under this HRA will be paid directly to the healthcare providers when under the terms of the integrated CDHP the claim is payable to the providers. Otherwise, the reimbursement under this

HRA will be paid to the person to whom the claim payment under the integrated CDHP is made.

F. Changes

For subsequent Plan Years, the Benefits, Accruals and Carryover limits, and any other terms and conditions of this HRA, may be changed by the Plan Administrator at its sole discretion, by notice to Employees and Retirees.

ARTICLE VI. HEALTH REIMBURSEMENT BENEFITS

A. Benefits

This Plan will reimburse Covered Persons for those Qualified Medical Expenses that are otherwise covered under the integrated CDHP but that are not reimbursed by the CDHP because they are adjudicated against the CDHP's deductible or a coinsurance amount that is the Covered Person's responsibility under the CDHP. Reimbursement will be made up to the Available Amount in the Participant's HRA Account at the time the claim is adjudicated under the integrated CDHP. Once the funds in the HRA Account are exhausted, no more Benefits will be paid for the Period of Coverage.

B. Incurral of Qualified Medical Expenses

A Covered Person may receive reimbursement under the HRA Account only for those covered Qualified Medical Expenses incurred during a Period of Coverage. A Qualified Medical Expense is incurred at the time the medical care, item or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Qualified Medical Expenses incurred before a Covered Person first becomes covered under the HRA, or after a Covered Person is terminated from the HRA, are not eligible for reimbursement.

C. Exclusions

This HRA will **not** reimburse Qualified Medical Expenses that are:

1. Health insurance premiums or contributions towards the cost of coverage for individual market health plans or for any other group health plan (including the integrated HDHC).

2. Pharmacy benefits covered under the integrated CDHP, whether prescribed or unprescribed.

3. Medications or drugs not covered under the integrated CDHP, whether prescribed or unprescribed.

4. Expenses for items or services excluded under the integrated CDHP.

5. Expenses for items or services determined to be not medically necessary or investigational under the integrated CDHP.

6. Expenses for routine vision services, eye exams, eyeglasses, frames or contact lenses.

7. Expenses for dental services, except those specifically covered under the medical portion of the integrated CDHP.

8. Expenses reimbursable under the integrated CDHP, or any other accident or health plan.

9. Expenses that are not specifically adjudicated towards the integrated CDHP's deductible or coinsurance.

D. Claims Prescription Period

Claims must be submitted to the Claims Administrator within twelve (12) months from the date that the expense is incurred, which is the date that the medical item or service was rendered ("Date of Service"). Qualified Medical Expenses will not be reimbursed under this HRA if the claim is submitted after this period.

ARTICLE VII. COORDINATION OF BENEFITS

Benefits under this Plan are solely intended to reimburse the covered Qualified Medical Expenses not previously reimbursed or reimbursable elsewhere. When the Covered Person has more than one health plan, this HRA will follow its integrated CDHP in its Coordination of Benefits and will pay Benefits only for those not otherwise reimbursed deductible or coinsurance amounts left over once the CDHP has finished adjudicating its claims.

When the Covered Person is entitled to reimbursement of a Qualified Medical Expense under this HRA and a Health Flexible Spending Arrangement (Health FSA) sponsored by the Plan Administrator, this HRA will pay its benefits first. Qualified Medical Expenses that are reimbursable under this HRA and also a Health FSA will only be reimbursed by the Health FSA after the funds of the Participant's HRA Account have been exhausted.

ARTICLE VIII. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP AND ALL COVERED PERSONS. THE GROUP IS THE PLAN ADMINISTRATOR FOR THIS PLAN.

BLUE CROSS AND BLUE SHIELD OF LOUISIANA PROVIDES ADMINISTRATIVE CLAIMS SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

A. This Plan

1. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the Plan Administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those that the Claims Administrator specifically undertake herein. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to Plan Participants for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or for Emergency Medical Services. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group’s failure to do so.

2. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.

3. The (Plan Administrator) shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

4. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant’s care or treatment.

5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

6. Except as specifically provided herein, this Benefit Plan will not make the Claims Administrator liable or responsible for any duty or obligation that is imposed on the Employer by federal or state law or regulations.

7. The Plan Administrator will not discriminate on the basis of race, color, religion, national origin, disability, sex, age, protected veteran or disabled status or genetic information; and shall not impose eligibility rules or variations in premium based on a Plan Participant’s health status or a health status-related factor.

B. Amending and Terminating the Plan

OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Participant, whether active or retired.

Any provision of the Plan which, on its Effective Date, is in conflict with applicable state law provisions (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

C. Employer Responsibility

1. The Participant Employer shall submit enrollment and change forms and all other necessary documentation to the Plan Administrator on behalf of its Participants. Employees of a Participant Employer will not, by virtue of furnishing any documentation to the Plan Administrator, be considered agents of the Plan Administrator, and no representation made by any such person at any time will change the provisions of this Plan.

2. A Participant Employer shall immediately inform the Plan Administrator when a Retiree with OGB coverage returns to full-time employment. The Retiree shall be placed in the Re-employed Retiree category for premium calculation. The Re-employed Retiree premium classification applies to Retirees with and without Medicare. The premium rates applicable to the Re-employed Retiree premium classification shall be identical to the premium rates applicable to the classification for Retirees without Medicare.

3. A Participant Employer who receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the OGB MSP Adjuster within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a Covered Person. If not timely forwarded, OGB will assume responsibility only for covered Plan benefits due to Medicare for a Covered Person. The Participant Employer will be responsible for interest, fines, and penalties due.

D. Benefits To Which Covered Persons are Entitled

1. The liability of the Plan Administrator is limited to the Benefits specified in this Plan. If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

2. Reimbursements for covered Benefits specified in this Plan will be provided only for services and supplies rendered on and after the Covered Person's Effective Date of coverage.

E. Retroactive Cancellation of Coverage

1. The Plan Administrator may retroactively cancel coverage in the following instances:

   a. To the extent the cancellation of coverage is attributable to a failure of the Plan Participant to timely pay required premiums, contributions and surcharges toward the cost of coverage; or

   b. The cancellation of coverage is initiated by the Plan Participant.

2. When the Plan Administrator retroactively cancels coverage, the Plan Participant shall be liable to the Plan Administrator for all benefits paid on behalf of the Plan Participant after the effective date of rescission or cancellation of coverage.

F. Termination of a Covered Person's Coverage Due to Fraud

The Plan may choose to rescind coverage or terminate a Covered Person's coverage if a Covered Person performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment form. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed or covered individual, shall constitute an intentional misrepresentation of material fact. A Covered Person's coverage may be rescinded retroactively to the effective date of coverage, or terminated within three (3) years of the Covered Person's effective date, for fraud or intentional misrepresentation of material fact. The Plan will give the Covered Person sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If you enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

G. Reinstatement to Position Following Civil Service Appeal

Self-Insured Covered Persons

When coverage of a terminated Employee, who was a participant in a self-insured health plan, is reinstated by reason of a civil service appeal, coverage will be reinstated to the same level in the Plan retroactive to the date coverage terminated. The Employee and Participant Employer are responsible for the payment of all premiums for the period of time from the date of termination to the date of the final order reinstating the Employee to his position. The Plan is responsible for the payment of all eligible Benefits for charges incurred during this period. All claims for expenses incurred during this period must be filed with the Plan within 60 days following the date of the final order of reinstatement.

H. Release of Information

The Claims Administrator may request that the Covered Person or the provider furnish certain information relating to the Participant's claim for Benefits.

The Claims Administrator will hold such information, records, or copies of records as confidential except where in the Claims Administrator's discretion the same should be disclosed.

I. Covered Person/Provider Relationship

1. The selection of a provider is solely the Covered Person's responsibility.

2. The Claims Administrator and all network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. The Claims Administrator does not render healthcare services, but only makes payment, on behalf of the Plan, for Benefits which the Covered Person receives. The Plan and the Claims Administrator will not be held liable for any act or omission of any provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Covered Person while receiving care from any network provider or in any network provider's facilities. The Plan and the Claims Administrator have no responsibility for a provider's failure or refusal to render services to the Covered Person.

3. The use or non-use of an adjective such as network and non-network in referring to any provider is not a statement as to the ability of the provider.

J. Notice

Any notice required under this Plan must be in writing. Any notice required to be given to a Covered Person will be considered delivered when deposited in the United States Mail, postage prepaid,

addressed to the Covered Person or the Participant at his address as the same appears on the Plan Administrator's records. Any notice that a Participant is required to give to the Plan Administrator must be given at the Plan Administrator's address as it appears in this Plan. The Plan or a Participant may, by written notice, indicate a new address for giving notice.

K. Subrogation and Reimbursement

Upon payment of any eligible Benefits covered under this Plan, the Office of Group Benefits plan shall succeed and be subrogated to all rights of recovery of the Plan Participant or his/her heirs or assigns for whose benefit payment is made and the Plan Participant shall execute and deliver instruments and papers and do whatever is necessary to secure such rights and shall do nothing to prejudice such rights. The Office of Group Benefits shall have an automatic lien against and shall be entitled, to the extent of any payment made to a Plan Participant and/or his/her heirs or assigns, to 100% of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a Plan Participant and/or his/her heirs or assigns against any person or entity legally responsible for the disease, illness, accident, or injury for which said payment was made.

To this end, Plan Participants agree to immediately notify the Office of Group Benefits or its agent assigned to exercise reimbursement and subrogation rights on its behalf of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident, or injury. These subrogation and reimbursement rights also apply, BUT ARE NOT LIMITED TO, when a Plan Participant recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

Under these subrogation and reimbursement rights, the Office of Group Benefits has a right of first recovery to the extent of any judgment, settlement, or any payment made to the Plan Participant and/or his/her heirs or assigns. These rights apply whether such recovery is designated as payment for pain and suffering, medical benefits, or other specified damages, even if the Plan Participant is not made whole (i.e., fully compensated for his/her injuries).

L. Right of Recovery

Whenever any payment for Benefits has been made by the Plan, in an amount that exceeds the maximum Benefits available for such services under this Plan, or exceeds the Allowable Charge, or whenever payment has been made in error by the Plan for non-covered services, the Plan will have the right to recover such payment from the Participant, the Dependent, or if applicable, the provider.

As an alternative, the Plan reserves the right to deduct, from any pending claim for payment under this Plan, any amounts the Covered Person or provider owes the Plan.

M. Coverage in a Department of Veterans Affairs or Military Hospital

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from the Plan to the extent the veteran would be eligible for Benefits for such care or services from the Plan if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

The United States will have the right to collect from the Plan the reasonable cost of healthcare services incurred by the United States on behalf of a military Participant or a military Dependent through a facility of the United States military to the extent that the Participant or Dependent would be eligible to receive reimbursement or indemnification from the Plan if the Retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

N. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a contract solely between the Plan Administrator and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Blue Cross and Blue Shield of Louisiana and its subsidiaries and affiliates (collectively “Blue Cross and Blue Shield of Louisiana”), to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Plan Administrator, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Plan Administrator for any of Blue Cross and Blue Shield of Louisiana's obligations to the Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of the claims administration agreement.

O. Out-of-Area Services

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”). Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever you obtain healthcare services outside the geographic area Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc service area, you will receive it from one of two kinds of Providers. Most Providers (“Participating Providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some Providers (“Non-Participating Providers”) do not contract with the Host Blue. The Claims Administrator explains below how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits when paid as medical Benefits, and those Prescription Drug Benefits or vision care Benefits that may be administered by a third party contracted by the Claims Administrator to provide the specific service or services.

1. BlueCard® Program

   Under the BlueCard® Program, when Plan Participants access covered healthcare services within the geographic area served by a Host Blue, Claims Administrator will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Network Providers.

   When you receive Covered Services outside Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. service area and the Claim is processed through the BlueCard® Program, the amount you pay for the Covered Services is calculated based on the lower of:

   - the billed covered charges for your Covered Services; or
   - the negotiated price that the Host Blue makes available to The Plan.

   Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host

Blue pays to the healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for your Claim because they will not be applied after a Claim has already been paid.

2. Special Case: Value-Based Programs

   a. BlueCard® Program

      If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

   b. Negotiated (non-BlueCard® Program) Arrangements

      If the Claims Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, the Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

   Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

4. Non-Participating Providers Outside Blue Cross and Blue Shield of Louisiana/HMO Louisiana Inc Service Area

   a. Plan Participant Liability Calculation

      When Covered Services are provided outside of Blue Cross and Blue Shield of Louisiana/HMO Louisiana Inc. service area by Non-Participating Providers, the amount you pay for such services will normally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Medical Services.

   b. Exceptions

      In certain situations, the Claims Administrator may use other payment methods, such as billed charges for Covered Services, the payment the Claims Administrator would make if the healthcare services had been obtained within Blue Cross and Blue Shield of Louisiana/HMO Louisiana Inc. service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services provided by Non-Participating Providers. In these

situations, you may be liable for the difference between the amount that the Non Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

5. Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard® service area"), you may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core Program is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard® service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, you should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global® Core Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your Deductible Amount and Coinsurance. In such cases, the Hospital will submit your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. You must contact the Claims Administrator to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

b. Outpatient Services

Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

c. Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for Covered Services outside the BlueCard® service area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of your Claim. The claim form is available from Blue Cross and Blue Shield of Louisiana/HMO Louisiana Inc., the Blue Cross Blue Shield Global® Core service center, or online at **www.bcbsglobalcore.com**. If you need assistance with your Claim submission, you should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, twenty-four (24) hours a day, seven (7) days a week.

P. Compliance with HIPAA Privacy Standards

The Plan Administrator's workforce performs services in connection with administration of the Plan. In order to perform these services, it is necessary for these workforce members, from time to time, to have access to Protected Health Information (as defined below).

Under the Standards of Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these workforce members are permitted to have such access subject to the following:

1. General

   The Plan shall not disclose Protected Health Information to any member of the Plan Administrator's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or Mental Health condition of a Covered Person, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

   Protected Health Information disclosed to members of the Covered Person's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and healthcare operations. The terms "payment" and "healthcare operations" shall have the same definitions as set out in the Privacy Standards, the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of Benefits or reimbursement for healthcare. "Healthcare Operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of healthcare providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

3. Authorized Workforce Members

   The Plan shall disclose Protected Health Information on to members of the Plan Administrator's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan

   For purposes of this HIPAA Privacy section, "members of the Plan Administrator's workforce" shall refer to all workforce members and other persons under the control of the Plan Administrator.

   a. Updates Required. The Plan Administrator shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

   b. Use and Disclosure Restricted. An authorized workforce member of the Plan Administrator's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

   c. Resolution of Issues of Noncompliance. In the event that any member of the Plan Administrator's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

(1) investigating the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach may include oral or written reprimand, additional training or termination of employment;

(3) mitigating any harm caused by the breach, to the extent practicable; and

(4) documenting the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Plan Administrator

The Plan Administrator agrees to:

a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Administrator with respect to such information;

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Plan of the Plan Administrator;

d. report any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. make available Protected Health Information to individual Covered Persons in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Covered Persons and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. make available Protected Health Information required to provide any accounting of disclosures to individual Covered Persons in accordance with Section 164.528 of the Privacy Standards;

h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. if feasible, return or destroy all Protected Health Information in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. ensure the adequate separation between the Plan and Covered Person of the Plan Administrator's workforce, as required by Section 164.504 (f) (2) (iii) of the Privacy Standards.

The following State of Louisiana, Office of Group Benefits workforce members are authorized to receive Protected Health Information in order to perform the following duties:

- Customer Service
- Agency Services
- Eligibility Services
- Executive Staff Services
- Contract Management Services
- IT Services
- Legal Services
- Medical Director Consultation Services
- Payment Services

Q. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan Administrator agrees to the following:

1. The Plan Administrator agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Plan Administrator creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Plan Administrator shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Plan Administrator shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections (3) Authorized workforce members and (4) Certification of Plan Administrator described above in this Article.

R. Compliance with the Affordable Care Act

This Plan shall be operated and administered in compliance with the applicable provisions of the Affordable Care Act ("ACA"), including IRC Section 4980H and the regulations promulgated thereunder. To the extent of any discrepancy between the terms of this Plan and the applicable requirements of the ACA, the Plan will be administered to comply with such applicable requirement.

ARTICLE IX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

OGB Eligibility Appeal Process

OGB retains the authority to make all determinations regarding eligibility, except for rescissions of coverage determinations and those determinations involving medical judgment regarding the incapacity of Over-Age 26 Dependents. All other eligibility appeals must be submitted within 180 calendar days following the denial of coverage to State of Louisiana Office of Group Benefits, Post Office Box 44036, Baton Rouge, Louisiana 70804 (rather than Blue Cross and Blue Shield of Louisiana) and OGB shall have sixty (60), rather than thirty (30) calendar days in which to respond to the appeal. Rescissions of coverage determinations and those determinations regarding the incapacity of Over-Age 26 Dependents shall be subject to the procedures set forth in Section C below.

Pharmacy Benefit Manager Appeals Process

Pharmacy Benefit Manager appeals information is available by calling CVS Caremark's Customer Contact Center at 877.300.1906 or by going to **www.groupbenefits.org**. Upon your written request, OGB will provide you a copy of the Pharmacy Benefit Manager appeals information at no charge.

A. COMPLAINTS AND GRIEVANCES: Quality of Care or Services

The Claims Administrator wants to know when a Plan Participant is dissatisfied with the quality of care or services received from the Claims Administrator or a Network Provider. If a Plan Participant or his Authorized representative wants to register an oral Complaint or file a formal written Grievance about the quality of care or services received from the Claims Administrator or a Network Provider, he should refer to the procedures below.

1. **Complaints**

   A Complaint is an oral expression of dissatisfaction with Us or with Provider services. A quality-of-service concern addresses appropriateness of care given to a Plan Participant, Our services, access, availability or attitude and those of Our Network Providers.

   To make a Complaint, call the Claims Administrator's customer service department at 1-800-392-4089. The Claims Administrator will attempt to resolve the Complaint at the time of the call.

   If a Plan Participant or his Authorized Representative is dissatisfied with the Claims Administrator's resolution, he may file a first level Grievance.

2. **Grievances**

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

   To file a first level Grievance, send the first level Grievance to:

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

   The Claims Administrator's customer service department will assist the Plan Participant or his Authorized Representative with filing the first level Grievance, if necessary.

The Claims Administrator will mail a response to the Plan Participant or his Authorized Representative within thirty (30) calendar days from the date the Claims Administrator receives the first level Grievance.

B. INFORMAL RECONSIDERATION: Pre-Service Denial Based on Medical Necessity or Investigational Determinations

In addition to the appeal rights, the Plan Participant's Provider may initiate an Informal Reconsideration to review Utilization Management decisions.

Informal Reconsideration

An Informal Reconsideration is a process to review Utilization Management decisions and is initiated by a request by telephone, made by an authorized Provider to speak to the Claims Administrator's Medical Director or to a peer reviewer. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

An Informal Reconsideration is available only if requested within **ten (10) calendar days** of the date of the initial denial or adverse Concurrent Review determination. The Claims Administrator will conduct the Informal Reconsideration within **one (1) business day** from the receipt of the request. Once the Informal Reconsideration is complete, the Claims Administrator will advise the Plan Participant or his Authorized Representative of the decision and, if necessary, the Plan Participant's additional appeal rights.

C. APPEALS: Standard Appeal, External and Expedited Appeals

A Plan Participant may be dissatisfied with coverage decisions made by the Claims Administrator. For example, rescissions of coverage, denied Authorizations, Investigational determinations, adverse Medical Necessity determinations, Adverse Benefit Determinations based on medical judgment, denied Benefits (in whole or in part), or adverse Utilization Management decisions.

A Plan Participant's appeal rights, including a right to an expedited appeal, are outlined below.

Standard Appeals Process

An Appeal is a **written** expression of dissatisfaction with coverage decisions made by the Claims Administrator. A Plan Participant or his Authorized Representative may file an administrative Appeal or a medical Appeal. The Plan Participant or his Authorized Representative is encouraged to submit written comments, documents, records, and other information relating to adverse coverage decisions.

If the Plan Participant or his Authorized Representative has questions or needs assistance putting an Appeal in writing, or wishes to communicate with the Claims Administrator regarding an Appeal, he may call the Claims Administrator's customer service department at 1-800-392-4089.

MULTIPLE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED, AT ANY LEVEL OF REVIEW.

The appeal process has two (2) mandatory levels of review. At each level of review, the review will involve persons who did not participate in any prior Adverse Benefit Determination and who are not a subordinate to any previous adverse decision-maker. When the Appeal requires medical judgment, the review will involve a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Administrative Appeals

Administrative Appeals involve contractual issues, Rescissions of Coverage, and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or Investigational.

1. First Level Administrative Appeal

If the Plan Participant is not satisfied with the Claims Administrator's decision, a written request must be submitted within **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination for first level administrative Appeals. Request submitted to the Claims Administrator after one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. If the administrative Appeal is denied, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The administrative Appeal decision will be mailed to the Plan Participant, the authorized representative, or Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request: unless the Claims Administrator and Plan Participant mutually agreed that an extension of the time is warranted.

All administrative Appeals should be submitted in writing to:

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

2. Second Level Administrative Appeal

After review of the Claims Administrator's first level Appeal decision, if the Plan Participant is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of receipt of the first level Appeal decision. Requests submitted after sixty (60) calendar days of receipt of the first level Appeal decision will not be considered.

An Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level Appeals. The Committee's decision is considered final and binding.

The Committee's decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within five (5) days of the Committee meeting.

Send a written request for further review and any additional information to:

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

3. OGB Voluntary Level Appeal

Not applicable to a rescission appeal or any appeal requiring medical judgment. These appeals follow the second level external review track for medical Appeals.

The Plan Participant or his Authorized Representative has **thirty (30) calendar days** from receipt of the notice denying the second level administrative Appeal to file an OGB voluntary level Appeal.

To file an OGB voluntary level Appeal, send the OGB voluntary level Appeal to:

Office of Group Benefits
Administrative Claims Committee
P. O. Box 44036
Baton Rouge, LA 70804

along with copies of all information relevant to the Appeal. Upon request by the Plan Participant and free of charge, the Claims Administrator will provide reasonable access to and copies of all documents, records, and other information relevant to the Adverse Benefit Determination. Send requests to: (Blue Cross and Blue Shield of Louisiana, Claims Administrator, Appeals and Grievance Unit, P. O. Box 98045, Baton Rouge, LA 70898-9045).

If the Administrative Claims Committee (ACC) grants the OGB voluntary level Appeal, the Claims Administrator will reprocess the claim. If the ACC denies the OGB voluntary level Appeal, the ACC will notify the Plan Participant or his Authorized Representative, in writing, of the decision within sixty (60) calendar days from the date the ACC received the OGB voluntary level Appeal, or as allowed by law.

Medical Appeals

Medical Appeals involve Adverse Benefit Determinations for Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational and any related prospective or retrospective review determination.

Medical Appeals should be submitted in writing to:

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

1. First Level Internal Medical Appeals

If the Plan Participant is not satisfied with the Claims Administrator's decision, a written request to Appeal must be submitted within **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination for internal medical Appeals. Requests submitted to the Claims Administrator after **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination will not be considered.

A healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, the Claims Administrator will reprocess the Plan Participant's Claim, if any. If the internal medical Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The internal medical Appeal decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request; unless the Claims Administrator and Plan Participant mutually agreed that an extension of the time is warranted.

If the first level Appeal is denied or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative may request a Second Level Appeal (External Review).

2. Second Level Medical / External Appeals

If the Plan Participant still disagrees with the determination on his Claim, or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative must send their written request for an external Appeal, conducted by a non-affiliated Independent Review Organization (IRO), within four (4) months of receipt of the internal Appeal decision, to:

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

Requests submitted to the Claims Administrator after four (4) months of receipt of the internal Appeal decision will not be considered. The Plan Participant is required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. **Appeals submitted by your Provider will not be accepted without this form completed with your signature.**

The Claims Administrator will conduct a preliminary review to determine whether the Plan Participant has a right to an external review within five (5) business days of receiving the request. The Claims Administrator will notify the Plan Participant or his Authorized Representative, in writing, of the decision and requirements for any further action by the Plan Participant or his Authorized Representative within one (1) business day after completing the preliminary review.

If an external review right exists, the Claims Administrator will provide the IRO all pertinent information necessary to conduct external Appeal. The external review will be completed within forty-five (45) days of receipt of the external Appeal request. The IRO will notify the Plan Participant or their authorized representative and all appropriate Providers of its decision.

The IRO decision is considered final and binding.

If you need help or have questions about your Appeal rights, call the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA or 1-866-444-3272.

Expedited Appeals Process

The Expedited Appeal process is available for review of an Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize the Plan Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare service for a Plan Participant currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the Plan Participant's treating Physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Expedited Appeals are not provided for review of services previously rendered.

An Expedited Appeal is available to, and may be initiated by the Plan Participant, the Plan Participant's representative, or a Provider authorized to act on the Plan Participant's behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

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

1. Expedited Internal Medical Appeals

In these cases, We will make a decision no later than seventy-two (72) hours of Our receipt of the internal medical Expedited Appeal request that meets the criteria for an Expedited Internal medical Appeal.

In any case where the internal medical Expedited Appeal process does not resolve a difference of opinion between Us and the Plan Participant or the Provider acting on behalf of the Plan Participant, the Appeal may be elevated to an Expedited External Appeal.

If the internal medical Expedited Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process and timeframe.

2. Expedited External Medical Appeal

A medical Expedited External Appeal is a request for immediate review, by an Independent Review Organization. The request may be simultaneously filed with a request for the internal medical Expedited Appeal, since IRO assigned to conduct medical review of the Expedited External Appeal will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for the medical Expedited External Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

D. No Surprises Act (NSA) Internal Appeals and External Appeals

The NSA added certain Plan Participant rights and protections that are eligible for internal Appeals and External Appeals. If a Plan Participant is dissatisfied about decisions. We make regarding the Plan Participant's rights and protections added by the NSA, the Plan Participant may file an Appeal. Examples of the NSA Plan Participant rights and protections include the following:

1. Plan Participant cost-sharing and surprise billing protections for Emergency Medical Services;

2. Plan Participant cost-sharing and surprise billing protections related to care provided by Non-Network Providers at Network facilities;

3. Whether Plan Participants are in a condition to receive notice and provide Informed Consent to waive the NSA protections;

4. Whether a Claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to Plan Participant cost-sharing and surprise billing; and

5. Continuity of care

The Plan Participant is encouraged to, and should, provide Us with all available information to help Us completely evaluate the NSA Appeal such as written comments, documents, records, and other information.

We will provide the Plan Participant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the determination that is the subject of the NSA appeal.

The Plan Participant has the right to appoint an authorized representative for NSA appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in an internal Appeal or External Appeal. The authorized representative may be the Plan Participant's treating Provider if the Plan Participant appoints the Provider in writing.

1. NSA Internal Appeals

   If a Plan Participant believes that We have not complied with the surprise billing and cost-sharing protections or with continuity of care of the NSA, a written request for review must be submitted within one hundred eighty (180) days of the NSA-related Adverse Benefit Determination. Requests submitted to Us after one hundred eighty (180) days of the NSA-related Adverse Benefit Determination will not be considered.

   The NSA internal Appeals request should be submitted in writing to:

   Blue Cross and Blue Shield of Louisiana

   Appeals and Grievance Unit

   P.O. Box 98045
   Baton Rouge, LA 70898-9045

   If a Plan Participant has questions or needs assistance, the Plan Participant may call Our customer service department at the number on the ID Card.

   We will investigate the Plan Participant's concerns. If the NSA internal Appeal is overturned, We will reprocess the Plan Participant's Claim, if applicable. If the NSA internal Appeal is upheld, We will inform the Plan Participant of the right to begin the NSA External Appeal process.

   The NSA internal Appeal decision will be mailed to the Plan Participant, the Plan Participant's authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) days of receipt of the Plan Participant's request, unless it is mutually agreed that an extension of time is warranted.

1. NSA External Appeals

   If a Plan Participant disagrees with the NSA internal Appeal decision, a written request for an NSA External Appeal must be submitted within four (4) months of receipt of the NSA internal Appeal decision. Requests submitted to Us after four (4) months of receipt of the NSA internal Appeal decision will not be considered.

   You are required to sign and return the form included in the NSA internal Appeal denial notice which authorizes release of medical records for review by the IRO. Appeals submitted by Your Provider will not be accepted without this form completed with Your signature.

   The NSA External Appeals request should be submitted in writing to:

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

   If the Plan Participant has questions or needs assistance, the Plan Participant may call Our customer service department at the number on the ID Card.

   A Plan Participant must exhaust all NSA internal Appeal opportunities prior to requesting an NSA External Appeal conducted by an IRO.

   We will provide the IRO all pertinent information necessary to conduct the NSA External Appeal. The external review will be completed within forty-five (45) days of Our receipt of the request for an NSA External Appeal. The IRO will notify the Plan Participant, his authorized representative, or a Provider authorized to act on the Plan Participant's behalf of its decision.

   The IRO decision will be considered a final and binding decision on both the Plan Participant and Us for purposes of determining coverage under this Benefit Plan. This NSA External Appeal process shall constitute Your sole recourse in disputes concerning whether the Company complied with the surprise billing and cost-sharing protections of the NSA, except to the extent that other remedies are available under state or federal law.

   The Plan Participant may contact 1-800-985-3059 or visit **www.cms.gov/nosurprises** for more information about Plan Participant rights under the NSA.

E. Exhaustion

The Plan Participant will have exhausted his administrative remedies under the Plan when the Plan Participant completes any one of the following steps:

- The OGB Eligibility Appeal process;
- Pharmacy Benefit Manager Appeal process;
- The Second Level Expedited Appeal process;
- The Second Level Internal Appeal process;
- The OGB Voluntary Level Appeal process; or,
- The External Review process.

After exhaustion, a claimant may pursue any other legal remedies available to him.

F. Legal Limitations

A Plan Participant must exhaust his administrative remedies before filing a legal action. A lawsuit related to a claim must be filed no later than twelve (12) months after the claim is required to be filed, or more than thirty (30) calendar days after the Plan Participant has exhausted his administrative remedies, whichever is later.

Any and all lawsuits, other than those related to claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

ARTICLE X. CARE WHILE TRAVELING, MAKING POLICY CHANGES AND FILING CLAIMS

The Claims Administrator is continuing to update its online access for Covered Persons. Covered Persons may now be able to perform many of the functions described below, without contacting the Claims Administrator's customer service department. The Claims Administrator invites Covered Persons to log on to **www.bcbsla.com** for access to these services.

All of the forms mentioned in this section can be obtained from the Claims Administrator's regional offices. If the Covered Person needs to submit documentation to the Claims Administrator, the Covered Person may forward it to Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA 70898-9029, or to, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Covered Person has any questions about any of the information in this section, the Covered Person may call the Claims Administrator's customer service department at the telephone number shown on his ID card.

A. How to Obtain Care While Traveling

The Participant's ID card offers convenient access to PPO healthcare outside of Louisiana. If the Covered Person is traveling or residing outside of Louisiana and needs medical attention, please follow these steps:

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

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

3. Use a designated PPO Network Provider to receive the highest level of Benefits.

4. Present the Participant's ID card to the Provider, who will verify coverage and file Claims for the Covered Person.

5. The Covered Person must obtain any required Authorizations from the Claims Administrator.

   NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States (out of country) are covered at the In-Network benefit level. Non-Emergency services received outside of the United States (out of country) ARE COVERED AT THE OUT-OF-NETWORK BENEFIT LEVEL.

B. How to File Claims for Benefits

Claims under this Plan will be processed and paid along with the claims of the integrated CDHP. Please refer to the CDHP's plan document for details about how claims are filed under that plan. Covered Persons do not need to file a separate claim to receive reimbursements under this HRA.

C. Claims Questions

Covered Person can also write Us at the address below or call Our customer service department at the telephone number shown on the ID card or visit any of Our local service offices*.

If the Covered Person calls for information about a Claim, We can help the Covered Person better if they have the information at hand, particularly the contract number, patient's name and date of service.

Remember, the Plan Participant should ALWAYS refer to their contract number in all correspondence and recheck it against the contract number on the ID card to be sure it is correct.

Blue Cross and Blue Shield of Louisiana,
5525 Reitz Avenue
P.O. Box 98027
Baton Rouge, LA 70898-9029

* Our local service offices are located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

ARTICLE XI. RESPONSIBILITIES OF PLAN ADMINISTRATION

A. Plan Administrator Responsibility

The OGB will administer the Plan in accordance with its terms, state and federal law, the OGB's established policies, interpretations, practices, and procedures. The OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding eligibility for benefits and to decide disputes which may arise relative to a Covered Person's rights.

B. Amendments to or Termination of the Plan and/or Contract

OGB has the statutory responsibility of providing Benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and Benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest Benefits for any Participant, whether active or retired, or a Dependent of an Eligible Employee or Retiree.

C. Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to the Covered Persons, and defraying reasonable expenses of administering the Plan. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation.

D. The Claims Administrator is not a Fiduciary

A Claims Administrator is NOT a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

ARTICLE XII **GENERAL PLAN INFORMATION**

NAME OF PLAN:

Health Reimbursement Arrangement for
State of Louisiana Employees

PLAN ADMINISTRATOR:

State of Louisiana Office of Group Benefits
Post Office Box 44036
Baton Rouge, Louisiana 70804

(225) 925-6625 or (225) 925-6770 (TDD)
(800) 272-8451 or (800) 259-6771 (TDD)

PLAN NUMBER (PN):

501

TYPE OF PLAN:

Health Reimbursement Arrangement

TYPE OF ADMINISTRATION:

The Plan is a self-funded Group Health Plan. Benefits are administered, on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administrative Services Agreement and the terms and conditions of the Plan.

CLAIMS ADMINISTRATOR:

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc
5525 Reitz Avenue
Baton Rouge, LA 70809
(800) 392-4089

Blue Shield of Louisiana/HMO Louisiana, Inc. has been hired to process claims under the Plan. Blue Shield of Louisiana/HMO Louisiana, Inc. does not serve as an insurer, but merely as a claims processor. Claims for Benefits are sent to Blue Shield of Louisiana/HMO Louisiana, Inc. Blue Shield of Louisiana/HMO Louisiana, Inc. processes and pays claims, then requests reimbursement from Plan. State of Louisiana, Office of Group Benefits is ultimately responsible for providing plan Benefits, and not Blue Shield of Louisiana/HMO Louisiana, Inc.

PLAN YEAR ENDS:

December 31

PLAN DETAILS:

The eligibility requirements, termination provisions, Benefits and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any Benefits are described in the Plan.

FUTURE OF THE PLAN:

Although the Plan Administrator expects and intends to continue the Plan indefinitely, the Plan Administrator reserves the right to modify, amend, suspend, or terminate the Plan at any time.

GENERAL NOTICE OF CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under certain circumstances when coverage would otherwise end under any of the Office of Group Benefits-sponsored health plans (hereinafter referred to as "Plan"). **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered by the State of Louisiana (such as life insurance).

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your Spouse and Dependent Children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should get a copy of the Plan Document from the Plan. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Office of Group Benefits, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your Spouse, and your Dependent Children could become qualified beneficiaries and would be entitled to elect COBRA coverage if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted Children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay the entire cost of COBRA coverage.

Who is entitled to elect COBRA Coverage?

If you are an Employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your Spouse. Also, if your Spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce. If you notify the Office of Group Benefits within 60 days after the divorce and can establish that the Employee cancelled the coverage earlier in anticipation of the divorce, the COBRA coverage may be available for the period after the divorce.

A person enrolled as the Employee's Dependent Child will be entitled to elect COBRA coverage, if he or she loses group health coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child."

When is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries only after the Office of Group Benefits has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the Employee, the Participant Employer must notify the Office of Group Benefits of the qualifying event within 30 days following the date coverage ends.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the Employee and Spouse, or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Office of Group Benefits in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You must follow the notice procedures specified by the Office of Group Benefits. If notice is not provided to the Office of Group Benefits during the 60-day notice period, ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

Once the Office of Group Benefits receives timely notice of the qualifying event, it will forward the information to its third-party COBRA Administrator, who will notify You of your right to elect COBRA coverage.

Electing COBRA

Once the Office of Group Benefits receives timely notice that a qualifying event has occurred, each qualified beneficiary will have an independent right to elect COBRA coverage. Once the Office of Group Benefits receives timely notice of the qualifying event, it will forward the information to its third-party COBRA Administrator, who will notify you of your right to elect COBRA coverage. Covered Employees and Spouses (if the Spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their Children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the covered Employee's divorce, or a Dependent Child's losing eligibility as a Dependent Child, COBRA coverage can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage under the Plan for his Spouse and Children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months

after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction in hours.

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Extension of COBRA Coverage

The COBRA coverage periods described above are maximum coverage periods. There are two ways in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration (or by the staff of the COBRA Administrator in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment) to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered Employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first (61st) day after the Covered Employee's termination of employment or reductions of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).
For persons eligible to receive Social Security disability benefits, the disability extension is available only if you notify the Office of Group Benefits and the COBRA Administrator in writing and submit a copy of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", the disability extension is available only if you submit to the COBRA Administrator in writing proof of total disability before the initial 18-month COBRA coverage period ends.

You must also provide this notice to the COBRA Administrator within 18 months after the covered Employee's termination of employment or reduction in hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" (you may obtain a copy of this form from the COBRA Administrator at no charge, or you can download the form at https://cobra.optumfinancial.com), and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period and within 18 months after the Employee's termination of employment or reduction of hours, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving 18 months of COBRA coverage because of the covered Employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the Spouse and Dependent Children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the Spouse and any Dependent Children receiving COBRA coverage if the Employee or former Employee dies, or gets divorced, or if the Dependent Child stops being eligible under the Plan as a

Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered Employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of:

- the date of the second qualifying event; and
- the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still an Employee covered under the Plan).

In providing this notice, you must use the COBRA Administrator's form, entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from the COBRA Administrator at no charge, or you can download the form at **https://cobra.optumfinancial.com**), **and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator within the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered Employee during COBRA coverage period

A Child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The Child's COBRA coverage begins on the Child's date of birth, date of adoption, or date of placement for adoption if the Child is enrolled in the Plan through the HIPAA Special Enrollment process designated by OGB, or on the first day of the following Plan Year if the Child is enrolled through Annual Enrollment. The COBRA coverage lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A Child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Office of Group Benefits during the covered Employee's period of employment with the Participant Employer is entitled to the same rights to elect COBRA as an eligible Dependent Child of the covered Employee.

Health Insurance Marketplace

There may be other coverage options for you and your family. Through the Affordable Care Act, you are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and Out-of-Pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity with another group health plan for which you are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you must keep the Office of Group Benefits and the COBRA Administrator informed of any changes in your address and the addresses of your covered family members. You should also keep a copy, for your records, of any notices you send to the Office of Group Benefits and/or the COBRA Administrator.

Plan Contact Information

You may obtain information about the Plan and COBRA coverage on request from:

Plan Information:

Office of Group Benefits
Eligibility Department
Post Office Box 44036
Baton Rouge, Louisiana 70804
1.800.272.8451
225.342.9917 FAX

COBRA Information:

Optum Financial
PO Box 2369
Omaha, NE 68103
1.855.272.8451
443.681.4606 FAX

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this notice, and you may obtain copies from the COBRA Administrator without charge or download them at **https://cobra.optumfinancial.com**). Oral notice, including notice by telephone, is not acceptable. Electronic e-mailed notices are not acceptable.

How, When, and Where to Send Notices: You must mail or FAX your notice to:

Optum Financial
PO Box 2369
Omaha, NE 68103
1.855.272.8451
443.681.4606 FAX

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If Faxed, your notice must be received by the Eligibility department at the number specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of COBRA coverage," and "Second qualifying event extension of COBRA coverage.")

Information Required for All Notices: Any notice you provide must include: (1) the name of the Plan; (2) the name and address of the Employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Notice Procedures (continued)

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce, your notice must include a copy of the decree of divorce. If your coverage is reduced or eliminated and later a divorce occurs, and if you are notifying the Office of Group Benefits that your Plan coverage was reduced or eliminated in anticipation of the divorce, your notice must include evidence satisfactory to the Office of Group Benefits that your coverage was reduced or eliminated in anticipation of the divorce.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination, if applicable; (5) a copy of the Social Security Administration's determination, if applicable; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled. For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", any notice of disability must also include proof of total disability, such as medical evidence presented by the applicant's physicians and the applicant's work history.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce, a copy of the decree of divorce.

Who May Provide Notices: The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

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

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

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

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)