Office of Group Benefits HMO Plan for State of Louisiana Employees & Retirees

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OFFICE OF GROUP BENEFITS
HMO PLAN for STATE of LOUISIANA EMPLOYEES and RETIREES
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ARTICLE I: UNDERSTANDING THE BASICS

As of the Original Effective Date of the Benefit Plan shown in the Schedule of Benefits, the Plan agrees to provide the Benefits specified herein for Employees of the Plan Sponsor and their enrolled Dependents. A copy of this Benefit Plan provided to Plan Participants serves as the Plan Participant's certificate of coverage. This Benefit Plan replaces any others previously issued to the Plan Sponsor.

Except for necessary technical terms, the Plan uses common words to describe the Benefits provided under this Plan. "We" "Us" and "Our" means Blue Cross and Blue Shield of Louisiana. Capitalized words are defined terms in Article II - "Definitions." A word used in the masculine gender applies also in the feminine gender, except where otherwise stated. THE GROUP IS THE PLAN SPONSOR AND THE PLAN ADMINISTRATOR OF 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 LIABILITY.

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

FACTS ABOUT THIS PLAN

The OGB HMO Benefit Plan for the State of Louisiana Employees and Retirees is a comprehensive Group health plan with Benefits similar to a point-of-service plan. It has Copayment, Deductible and Coinsurance Benefits. A Plan Participant may choose to receive Benefits from a Network Provider or a Provider outside the Network (Non-Network Provider). A Plan Participant will usually pay a Copayment when seeking care from a Network Provider, and will pay Deductible and Coinsurance for services received from a Non-Network Provider. The Plan Participant's choice of a Provider usually determines whether a Copayment or Deductible/Coinsurance applies.

Effective January 1, 2012, all Deductibles, Out-of-Pocket Amounts, Coinsurance, Copayments and annual limits (day and dollar) will start over and all Benefits in this Plan will apply on a calendar basis.

THE CLAIMS ADMINISTRATOR'S PROVIDER NETWORK

Plan Participants have the right to use Providers of their choice. The Plan Participant's choice of Provider will impact the amount the Plan Participant pays for Covered Services.

The Plan's Provider Network is called the PREFERRED CARE (OR PCARE) NETWORK. It consists of a select Group of Physicians, Hospitals and other Allied Providers that have contracted with the Claims Administrator to participate in the OGB HMO Preferred Care Provider Network and render services to the Plan Participants. These Providers are called "Preferred Providers," or "Network Providers." Plan Participants may access care at the In-Network level of Benefits when they see contracted PPO Providers in other states, through the BlueCard® Program. Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's dental network.

In an Emergency, Plan Participants should seek care from the nearest facility, even if that facility is not in the Plan's Network. For non-emergency care, the Plan Participant should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Provider before the service is rendered. Plan Participants may review a current paper Provider directory, check on-line at **www.bcbsla.com**, or contact the Plan's Customer Service Department at the number on his ID card. A Provider's status may change. The Plan Participant should always verify the Network status of a Provider before obtaining services.

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

Additionally, Providers in Your network may be contracted to perform certain Covered Services, but may not be contracted in Your network to perform other Covered Services. When a Network Provider performs services that the Network Provider is not contracted with the Claims Administrator to perform (such as certain high-tech

diagnostic or radiology procedures), Claims for those services will be adjudicated at the Non-Network Benefit level. The Plan Participant should make sure to check his Provider directory to verify that the services are In-Network when performed by the Provider or at the Provider's location.

AUTHORIZATIONS

CERTAIN SERVICES LISTED ON THE SCHEDULE OF BENEFITS REQUIRE AUTHORIZATION BY THE CLAIMS ADMINISTRATOR. IF AN AUTHORIZATION IS NOT OBTAINED PRIOR TO SERVICES BEING RENDERED, NO BENEFITS WILL BE PAID AND THE CLAIM WILL BE DENIED.

An Authorization is the Plan's determination that it is Medically Necessary for the Plan Participant to receive the requested medical services. When the Claims Administrator authorizes a service for Medical Necessity, the Claims Administrator is not making a determination about the Plan Participant's choice of Provider or the Benefits that will apply to a resulting Claim.

PRIOR AUTHORIZATION IS NOT REQUIRED FOR AN EMERGENCY MEDICAL SERVICE, AS DEFINED BY THIS BENEFIT PLAN.

Network Providers are required to obtain necessary Authorizations on behalf of the Plan Participant. When a Network Provider fails to obtain a required Authorization, the Plan penalizes the Network Provider, not the Plan Participant. The Plan Participant continues to be responsible only for the applicable Network Copayment, Deductible, and/or Coinsurance shown in the Schedule of Benefits.

When the Claims Administrator issues an Authorization but the Plan Participant receives the service from a Non-Network Provider, no Benefits are payable unless the Plan Participant obtained the Claims Administrator's written approval to obtain the services from the Non-Network Provider, PRIOR TO THE SERVICES BEING RENDERED. If the Plan Participant has received the Claims Administrator's written approval to use a Non-Network Provider, it is up to the Plan Participant to make sure that the approved Provider obtains any necessary Authorizations, or no Benefits will be paid.

No payment will be made for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless the Claims Administrator Authorizes these services and the services are rendered by a Blue Distinction Center for Transplants or a transplant facility in the Preferred Care Network, unless otherwise approved by the Claims Administrator in writing. To locate an approved transplant facility, Plan Participants should contact the Plan's customer service department at the number listed on their ID card.

The Plan Participant should know that care received from a Non-Network physician, facility or other health care professional means a higher Copayment, Deductible, and/or Coinsurance. In addition, if the Plan Participant chooses to seek care outside the Network, the Plan will only pay a portion of those charges and it is the Plan Participant's responsibility to pay the remainder. The amount the Plan Participant is required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. The Plan recommends that the Plan Participant ask the Non-Network physician or health care professional about their billed charges before receiving care.

In some cases, In-Network Benefits may be paid to Non-Network Providers whose services are not available by an In-Network Provider. Prior Authorization is required. The In-Network Benefits will be based on the In-Network Allowable Charge. The Plan Participant can be balance-billed by the Provider.

HOW THE PLAN DETERMINES WHAT IS PAID FOR COVERED SERVICES

The Plan bases payments of Benefits for a Plan Participant's Covered Services on an amount known as the "Allowable Charge." The Allowable Charge depends on the Provider from whom the Plan Participant receives Covered Services as described below, and may be different for Preferred Providers, Participating Providers and Non-Participating Providers. If the amount that is billed for Covered Services by the Plan Participant's Provider is less than the amount that the Claims Administrator has negotiated for the Covered Service, the billed amount is the Allowable Charge and the Plan's payment will be based on the billed amount.

When a Plan Participant Uses Preferred Providers

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

When a Plan Participant Uses Participating Providers/Non-Network Providers

Participating Providers are Providers who have signed contracts with the Claims Administrator or another Blue Cross and Blue Shield plan to treat Plan Participants for favorable negotiated fees, but for a network other than the Plan Participant's network. These Providers have agreed to accept the lesser of billed charges or the negotiated amount as payment in full for Covered Services provided to the Plan Participant. This amount is the Participating Provider's Allowable Charge. When a Plan Participant uses a Participating Provider, this Allowable Charge is used to determine the amount the Plan pays for Medically Necessary Covered Services and the amount the Plan Participant pays.

When a Plan Participant Uses Non-Participating Providers/Non-Network Providers

Non-Participating Providers are Providers that have not signed any contract with the Claims Administrator or any other Blue Cross Blue Shield plan to participate in any Blue Cross Blue Shield Network. These Providers are not in the Claims Administrator's Networks. The Claims Administrator has no fee arrangements with them. The Plan establishes an Allowable Charge for Covered Services provided by Non-Participating Providers. The Plan uses the lesser of the Provider's actual billed charge or the established Allowable Charge to determine what to pay for a Plan Participant's Covered Services when the Plan Participant receives care from a Non-Participating Provider. The Plan Participant will receive a lower level of Benefits because he did not receive care from a Preferred Provider.

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

ASSIGNMENT

A Plan Participant's rights and Benefits under this Plan are personal to the Plan Participant and may not be assigned in whole or in part by the Plan Participant. The Claims Administrator will not recognize assignments or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the health plan or the Claims Administrator liable to any third party to whom a Plan Participant may be liable for the cost of medical care, treatment, or services.

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

PLAN PARTICIPANT INCENTIVES

Sometimes the Plan offers coupons, discounts, or other incentives to encourage Plan Participants to participate in various programs such as pharmacy programs, wellness programs, or disease management programs. A Plan Participant may wish to decide whether to participate after discussing such programs with their Physicians. These incentives are not Benefits and do not alter or affect Plan Participant Benefits.

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

CUSTOMER SERVICE E-MAIL ADDRESS

The Claims Administrator has consolidated its customer service e-mails into a single, easy-to-remember address: **ogbhelp@bcbsla.com**. Customers who need to contact the Claims Administrator may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit **www.bcbsla.com** and click on "Contact the Claims Administrator," found at the upper right of every web page.

HOW TO OBTAIN CARE USING BLUECARD® WHILE TRAVELING

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

- In an Emergency, go directly to the nearest Hospital.
- Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest PPO doctors and Hospitals.
- Use a designated PPO Provider to receive Network Benefits.
- Present the Plan Participant's ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant. (Plan Participants may be required to pay professional Providers and seek reimbursement).
- The Plan Participant must obtain any required Authorizations from the Claims Administrator.

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States (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.

ARTICLE II. DEFINITIONS

Accidental Injury - A condition, which is a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, injuries caused by the act of chewing do not constitute an injury caused by external force.

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

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

Allied Health Professional - A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, and/or approved by the Claims Administrator to render Covered Services. For coverage purposes under this Benefit Plan, Allied Health Professionals include, but are not limited to audiologists, dentists, psychologists, Retail Health Clinics, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, Physician's assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, midwives, optometrists, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by the Claims Administrator to render Covered Services.

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

Allowable Charge – The lesser of the billed charge or the amount established by the Claims Administrator or negotiated as the maximum amount allowed for all Provider services covered under the terms of this Benefit Plan.

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

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

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

Annual Enrollment - A period of time, designated by the Group, during which a Employee and their eligible Dependents may enroll for Benefits under this Benefit Plan.

Annual Enrollment Period - Unless otherwise specified in the Schedule of Benefits, the Annual Enrollment Period means the enrollment period prior to the beginning of each Plan Year.

Appeal – A request from a Plan Participant or authorized representative to change a previous decision made by the Claims Administrator about covered services. Examples of issues that qualify as appeals include denied Authorizations, Claims based on adverse determinations of Medical Necessity or benefit determinations.

Applied Behavioral Analysis (ABA) - The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Providers of ABA shall be certified as a behavior analyst by the Behavior Analyst Certification Board or shall provide, upon request, documented evidence satisfactory to Company, of equivalent education, professional training, and supervised experience in ABA.

Authorization (Authorized) – A determination by Claims Administrator regarding an Admission, continued Hospital stay, or other health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the health care setting, or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Plan Participant's choice of Provider. Services requiring an Authorization are listed on the Schedule of Benefits. Failure to obtain an Authorization will result in no Benefits paid and the Claim will be denied.

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

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

Benefits – Coverage for health care services, treatment, procedures, equipment, drugs, devices, items or supplies provided under this Plan. Benefits provided by the Plan are based on the Allowable Charge for Covered Services.

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

Benefit Plan - This agreement, including any Applications for Coverage, Schedule of Benefits and amendments/endorsements to this agreement, if any, entitling the Plan Sponsor's Employees, Retirees and their Dependents to Benefits.

Benefit Plan Date – The date upon which the Group agrees to begin providing Benefits for Covered Services to Plan Participants under this Benefit Plan.

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

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

Child or Children includes:

A. a Child of the Employee and/or the Employee's legal spouse; or

B. a Child in the process of being adopted by the Employee through an agency adoption; or

C. a Child under the guardianship or in the legal custody of the Employee; or

D. a Grandchild of the Employee who is not in the legal custody of the Employee, whose parent is a covered Dependent. If the Employee seeking to cover a Grandchild is a paternal grandparent, the Program will require that the biological father, i.e. the covered son of the Employee, execute an acknowledgement of paternity.

Note: If the Employee Dependent parent becomes ineligible for coverage under the Program, the Employee's Grandchild will also be ineligible for coverage, unless the Employee has legal custody of his Grandchild.

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

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

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

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

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

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

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

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

Congenital Anomaly - A condition existing at or from birth, which significantly interferes with normal bodily function. For purposes of this Benefit Plan, the Plan will determine what conditions will be covered as Congenital Anomalies. In no event will the term Congenital Anomaly include conditions relating to teeth or structures supporting the teeth, except for cleft palate.

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

Copayment - The amount of charges for a Covered Service, which a Plan Participant must pay for specified Covered Services. The Copayment may be collected directly from a Plan Participant by a Network Provider each time a specified Covered Service is rendered. All Copayments accrue to the Plan Participant's Out-of-Pocket maximum.

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

Covered Person – An active or retired Employee, his eligible Dependent, or any other individual eligible for coverage for whom the necessary application forms have been completed, for whom the required contribution has been made, and whom the Group has accepted Eligibility and enrolled into the Plan. The terms Covered Person, defined here are used interchangeably with the terms Plan Participant.

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

Creditable Coverage for HIPAA Portability - Prior coverage under an individual or Group health plan including, but not limited to, Medicare, Medicaid, government plan, church plan, COBRA, military plan or state children's health insurance program (e.g. LaCHIP). Creditable coverage does not include specific disease policies (i.e., cancer policies), supplemental coverage (i.e., Medicare Supplement) or limited Benefits (i.e., accident only, disability insurance, liability insurance, workers' compensation, automobile medical payment insurance, credit only insurance; coverage for on-site medical clinics or coverage as specified in federal regulations under which Benefits for medical care are secondary or incidental to the insurance Benefits).

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

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

A. Legal Spouse – the date of marriage

B. Child or Children

   1. Natural Children – the date of birth

   2. Children in the process of being adopted

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

      Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee. The Program 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.

      a. Child under the guardianship or in the legal custody of the Employee – the date of the court order granting guardianship or custody, or the effective date of the notarized act granting provisional custody in proper statutory form and substance.

      b. Grandchild of the Employee who is not in the legal custody of the Employee whose parent is a covered Dependent.

         (1) The date of birth of the Grandchild, if all of the above requirements are met at the time of birth; or

         (2) The date on which the coverage becomes effective for the covered Dependent, if all of the above requirements are not met at the time of birth.

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

Deductible Amounts

A. Benefit Period Deductible Amount is the dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Plan Participant must pay within a Benefit Period before Benefits are provided. Non-Network Benefits carry a Benefit Period Deductible Amount as shown in the Schedule of Benefits.

B. Family Deductible Amount, if shown in the Schedule of Benefits, is the dollar amount of charges for covered services that a Family must pay within a Plan Year. Once a family has met its Family Deductible, this Plan starts paying Benefits for all members of the family, regardless of whether each individual has met his individual amount. Family Deductibles may apply to other types of Deductibles if described in this Benefit Plan.

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

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

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

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

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

A. the covered Employee's legal Spouse;

B. a Child from date acquired until attainment of age twenty-six (26);

C. a Child of any age who meets the criteria set forth in Article 1 Section B (4) herein.

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

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

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

B. Child

1. Natural or legally adopted child of plan member - Certified copy of birth certificate listing plan member as parent or certified copy of legal acknowledgment of paternity signed by plan member or certified copy of adoption decree naming plan member as adoptive parent.

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

3. Child placed with your family for adoption by agency adoption or irrevocable act of surrender for private adoption. Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender.

4. Child for whom you have been granted guardianship or legal custody, including provisional custody - Certified copy of the court order granting legal guardianship or custody, or the original notarized act granting provisional custody in proper statutory form and substance.

5. Grandchild for whom you do not have legal custody or guardianship whose parent is a covered dependent - Certified birth certificate or adoption decree showing parent of grandchild is dependent child and certified copy of birth certificate showing dependent child is parent of grandchild.

6. Child age twenty-six (26) or older who is incapable of self-sustaining employment and who was covered prior to and upon attainment of age twenty-six (26) - Documentation as described in B(1) through B(6) above together with an application for continued coverage supporting medical documentation prior to the child's attainment of age twenty-six (26) as well as additional medical documentation of child's continuing condition periodically upon request by OGB.

C. Such other written proof of relationship to the Employee deemed sufficient by OGB.

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

Effective Date - The date when a Plan Participant's coverage begins under this Benefit. Benefits will begin at 12:01 AM on this date.

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

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

Eligibility Waiting Period - The period that must pass before an individual's coverage can become effective for Benefits under this Benefit Plan. If an individual enrolls as a Special or Late Enrollee, any period before such Special or Late Enrollment is not an Eligibility Waiting Period.

Emergency - See "Emergency Medical Condition."

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

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

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

Employee – A full-time Employee as defined by a Participant Employer and in accordance with state law.

Enrollment Date - The first day of coverage under this Benefit Plan or, if there is an Eligibility Waiting Period, the first day of the Eligibility Waiting Period. For a Late Enrollee, the Enrollment Date is the first day of coverage.

Expedited Appeal - Any request concerning an Admission, availability of care, continued stay, or health care service for a Covered Person or his authorized representative who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility.

Expedited External Appeal - A request for immediate review, by an Independent Review Organization (IRO), of an initial adverse determination, not to authorize continued services for Plan Participants currently in the Emergency room, under observation, or receiving Inpatient care.

Grievance - A written expression of dissatisfaction with the Claims Administrator or with Provider services.

Group – See OFFICE OF GROUP BENEFITS.

Home Health Care - Health services rendered in the individual's place of residence by an organization licensed as a Home Health Care agency by the appropriate state agency and that the Claims Administrator approves. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse (RN) licensed to practice in the state.

Hospice Care - Provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Plan Participants and their families during the final stages of terminal illness. Full scope health services are centrally coordinated through an interdisciplinary team directed by a Physician and provided by or through a Hospice Care agency that the Claims Administrator approves.

Hospital - An institution that is licensed by the appropriate state agency as a general medical surgical Hospital. The term Hospital may also include an institution that primarily provides rehabilitation, skilled nursing, long term, intermediate care, or other specialty care.

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

Independent Review Organization (IRO) - An Independent Review Organization not affiliated with the Claims Administrator, which conducts external reviews of final adverse determinations. The decision of the IRO is binding on both the insured and the Company.

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

Informal Reconsideration - A request by telephone for additional review of a Utilization Management determination not to authorize. Informal reconsideration is available only for initial or Concurrent Review determinations that are requested within ten (10) days of denial.

Inpatient - A Plan Participant who is a registered bed patient for whom a Bed, Board and General Nursing Service charge is made. An Inpatient's medical symptoms or condition must require continuous twenty-four (24) hour a day Physician and nursing intervention. If the services can be safely provided to the Plan Participant as an Outpatient, the Plan Participant does not meet the criteria for an Inpatient.

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

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

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

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

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

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

3. reference to federal regulations.

Late Enrollee – An individual who enrolls in this Benefit Plan other than during the initial period in which he is eligible to enroll or other than during any Special Enrollment Period. Also see, Overdue Applicant.

Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. in accordance with nationally accepted standards of medical practice;

B. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

C. not primarily for the personal comfort or convenience of the patient or Provider, and not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies or sequence thereof and that are as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

   For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

Network Benefits - Benefits for care received from a Network Provider.

Network Provider - A Provider that has signed an agreement with the Claims Administrator or another Blue Cross and Blue Shield plan to participate as a Plan Participant of the Preferred Care Provider Network or another Blue Plan's PPO Network.

Newly-Born Infant - An infant from the time of birth until age one (1) month or until such time as the infant is well enough to be discharged from a Hospital or neonatal Special Care Unit to his home, whichever period is longer.

Non-Network Benefits – Benefits for care received from Non-Network Providers.

Non-Network Provider - A Provider who is not a Plan Participant of the Preferred Care Network or another Blue Cross Blue Shield plan PPO Network.

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.

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

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

Out-of-Pocket Amount - The maximum amount of unreimbursable expenses (in addition to any applicable Deductible Amount) that a Plan Participant must pay for Covered Services in a Benefit Period, as defined in this Benefit Plan.

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

Overdue Applicant - An individual who enrolls in this Benefit Plan other than during the initial period in which he is eligible to enroll or other than during any Special Enrollment Period.

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

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

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

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

Plan – Coverage offered by the Office of Group Benefits under this contract, prescription drug benefits, disease management, mental health and substance abuse benefits, and comprehensive medical benefits. The term Plan is used interchangeably with the term Program.

Plan Administrator - The Office of Group Benefits HMO Plan for State of Louisiana Employees And Retirees Medical Benefit Plan is the Benefit Plan of OGB, the Plan Administrator, also called the Plan Sponsor.

Plan Participant - A Covered Person or enrolled Dependent.

Plan Year - A period of time beginning with the Effective Date of this Benefit Plan or the anniversary of this date and ending on the day before the next anniversary of the Effective Date of this Benefit Plan.

Pre-Existing Condition - A physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the one-hundred and eighty (180) day period immediately prior to the enrollment date. Pre-existing conditions are covered at the end of a twelve (12) month period following the enrollment date (first day of coverage or if there is a waiting period, the first day of the waiting period). Pre-Existing Condition limitations will be waived or reduced for Pre-Existing Conditions that were satisfied under previous Creditable Coverage. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

Pre-Existing Condition Exclusion Period - The time period, as specified in the Limitations and Exclusions Article of this Benefit Plan, during which services for a Pre-Existing Condition are not covered under this Benefit Plan. No Pre-Existing Condition Exclusion Period shall apply to Eligible Persons under the age of nineteen (19).

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

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

Preventive or Wellness Care (Routine Care) - Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage.

Private Duty Nursing Services - Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is unrelated to the patient by blood, marriage or adoption. These services must be ordered by the attending Physician and require the technical skills of an RN or LPN in shifts of at least eight (8) continuous hours.

Program – The Office of Group Benefits Program or Plan.

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

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

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

A. Preferred Provider – A Provider that has signed an agreement with the Claims Administrator or another Blue Cross and Blue Shield plan to participate as a Plan Participant of the Preferred Care Provider Network or another Blue Plan's PPO Network.

B. Participating Provider – A Provider that has a signed contract with the Claims Administrator or HMO Louisiana, Inc. for other than the Preferred Care Network, or has a signed contract with another Blue Cross and Blue Shield plan to participate in a Non-PPO network.

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

Rehabilitative Care - The coordinated use of medical, social, educational or vocational services, beyond the acute care stage of disease or injury, for the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

Residential Treatment Center – A twenty-four (24) hour, non-acute care treatment setting.

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

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

A. immediately received retirement benefits from an approved state or governmental agency defined Benefit Plan;

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

    1. began employment prior to September 15, 1979, has ten (10) years of continuous state service, and has reached the age of sixty-five (65); or

    2. began employment after September 16, 1979, has ten (10) years of continuous state service, and has reached the age of seventy (70); or

    3. was employed after July 8, 1992, has ten (10) years of continuous state service, has a credit for a minimum of forty (40) quarters in the Social Security system at the time of employment, and has reached the age of sixty-five (65); or

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

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

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

Significant Break in Coverage - A period of sixty-three (63) or more consecutive days during all of which an individual does not have any Creditable Coverage. Periods without coverage during an Eligibility Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in coverage has occurred.

Skilled Nursing Facility or Unit - A facility licensed by the state in which it operates and is other than a nursing home, or a unit within a Hospital that provides:

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

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

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

D. Utilization review plans for all patients.

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

Special Enrollee - An Eligible Person who is entitled to and who requests special enrollment (as described in this Benefit Plan) within thirty (30) days of losing other certain health coverage or acquiring a new Dependent as a result of marriage, birth, adoption or placement of adoption.

Specialty Drugs - Biotechnology drugs or other drug products that may require special ordering, handling, and/or customer service, examples of which include, but are not limited to protein drugs, monoclonal antibodies, interferons, antisense drugs, epidermal growth factor inhibitors, and gene therapies.

Speech/Language Pathology Therapy - The treatment of a speech/language impairment or a swallowing impairment to improve or restore speech language deficits or swallowing deficits.

Surgery

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

B. The correction of fractures and dislocations.

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

D. Usual and related pre-operative and post-operative care.

E. Other procedures that the Claims Administrator defines and approves.

Temporarily Medically-Disabled Mother - A woman who has recently given birth and whose Physician has advised that normal travel would be hazardous to her health.

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

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

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

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

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

Utilization Management – See Utilization Review Organization (URO).

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

Waiting Period - see "Eligibility Waiting Period."

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

ARTICLE III. SCHEDULE OF ELIGIBILITY

ANY ELIGIBILITY REQUIREMENT LISTED IN THIS BENEFIT PLAN, WHICH IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS.

A. Persons to be Covered

1. Employee

   a. A full-time Employee as defined by a Participant Employer and in accordance with state law

   b. Husband and Wife, Both Employees - NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE. If a covered spouse chooses to be covered separately at a later date and is eligible for coverage as an Employee, that person will be a covered Employee 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

      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) 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) 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 completed after thirty (30) days following the date of employment, the Employee will be considered an Overdue Applicant.

      (4) An Employee who transfers employment to another Participating Employer must complete a transfer form within thirty (30) days following the date of transfer to maintain coverage without interruption. If completed after thirty (30) days following the date of transfer, the Employee will be considered an Overdue Applicant and may be subject to pre-existing limitations. Overdue Applicants age nineteen (19) and older may be subject to the Pre-Existing Exclusion Period.

   d. Re-Enrollment, Previous Employment for Health Benefits

      (1) An Employee, whose employment terminated while covered and is re-employed within twelve (12) months of the termination date, will be considered a Re-Enrollment Previous Employment applicant. A Re-Enrollment Previous Employment applicant will only be eligible for the classification of coverage (Employee, Employee and child(ren), Employee and spouse, Family) in force on the effective termination date.

      (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. Plan Participants of Boards and Commissions

      Except as otherwise provided by law; Plan Participants of boards or commissions 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

Legislative Assistants are eligible to participate in the Plan if they are declared full-time Employees by the Participant Employer and have at least one year of experience or receive at least eighty-percent (80%) of their total compensation as Legislative Assistants.

g. Pre-Existing Condition (PEC) – New Employees

(1) The terms of the following paragraph apply to all eligible Employees and their Dependents whose employment with a Participating Employer begins on or after July 1, 2001.

(2) The Program may require that such applicants complete a "Statement of Physical Condition" form and an "Acknowledgment of Pre-Existing Condition" form.

(3) Medical expenses incurred during the first twelve (12) months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately prior to the enrollment date of coverage. The provisions of this section do not apply to pregnancy or to Dependents under the age nineteen (19).

(4) If the Covered Person was previously covered under a Group Health Plan, Medicare, Medicaid, or other creditable coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred without a break for sixty-three (63) days or more for the duration of prior coverage against the initial twelve (12)-month period. Any coverage occurring prior to a break in coverage, sixty-three (63) days or more will not be credited against a Pre-Existing condition exclusion period.

2. Retiree Coverage - Eligibility

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

b. An Employee retired from a Participant Employer may not be covered as an Employee.

c. Retirees are not eligible for coverage as Overdue Applicants.

d. 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 example, if retired July 15th, coverage will begin August 1st).

3. Documented Dependent Coverage - Eligibility

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

(1) The date the Employee becomes eligible;

(2) The date the Retiree becomes eligible; or

(3) The date the covered Employee or covered Retiree acquires a Dependent. No Pre-Existing Condition Exclusion Period shall apply to Dependents under the age of nineteen (19).

b. Effective Dates of Coverage

(1) Documented Dependents of Employee -Coverage will be effective on the date the Employee becomes eligible for Dependent coverage.

(2) Documented Dependents of Retirees -Coverage for Dependents of Retirees will be effective on the first day of the month following the date of retirement if the Employee and his Dependents were

covered immediately prior to retirement. Coverage for Dependents of Retirees first becoming eligible for Dependent coverage following the date of retirement will be effective on the date of marriage for new spouses, the date of birth for newborn children, or the date acquired for other classifications of Dependents. Application must be made within thirty (30) days of the date of eligibility for coverage.

4. Pre-Existing Condition – Overdue Application

   a. The terms of the following paragraphs apply to all eligible Employees who apply for coverage after thirty (30) days from the date the Employee became eligible for coverage and to all eligible Dependents of Employees and Retirees for whom the application for coverage was not completed within thirty (30) days from the date acquired. The effective date of coverage will be:

      (1) The first day of the month following the date the Program receives all required forms prior to the fifteenth (15^{th}) of the month.

      (2) The first day of the second month following the date the Program receives all required forms on or after the fifteenth (15^{th}) of the month.

   b. The Program will require that all Overdue Applicants complete a "Statement of Physical Condition" form and an "Acknowledgement of Pre-Existing Condition" form.

   c. Medical expenses incurred during the first twelve (12) months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) month period immediately prior to the enrollment date of coverage. The provisions of this section do not apply to pregnancy or to Dependents under the age of nineteen (19).

   d. If the Covered Person was previously covered under a group health plan, Medicare, Medicaid or other creditable coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred continuously for sixty-three (63) days or more for the duration of prior coverage against the initial twelve (12)-month period. Any coverage occurring prior to a break in coverage sixty-three (63) days or more will not be credited against a Pre-Existing Condition exclusion period.

5. Special Enrollments – HIPAA

   In accordance with HIPAA, certain eligible persons for whom the option to enroll for coverage was previously declined, and who would be considered Overdue Applicants, may enroll by written application to the Participant Employer under the following circumstances, terms, and conditions for special enrollments.

   a. Loss of Other Coverage - Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined because the Employees or Dependents had other coverage which terminated due to:

      (1) Loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the Plan Participant; or

      (2) Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer's contributions were ceased for cause or for failure of the individual participant to make contributions; or

      (3) The Employee or Dependent having had COBRA continuation coverage under a Group Health Plan and the COBRA continuation coverage has been exhausted, as provided in HIPAA; or

      (4) Effective April 1, 2009: Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or

(5) Effective April 1, 2009: Eligibility for premium assistance subsidy under Medicaid or SCHIP.

b. After-Acquired Dependents - Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined when the Employee acquires a new Dependent by marriage, birth, adoption, or placement for adoption.

(1) A special enrollment application must be made within thirty (30) days of either the termination date of the prior coverage or the date the new Dependent is acquired, or within sixty (60) days as identified in #4 and #5 above. If the special enrollment application is made more than thirty (30) days, after eligibility or within sixty (60) days as identified in #4 and #5 above, they will be considered Overdue Applicants subject to a Pre-Existing Condition limitation. No Pre-Existing Condition Exclusion Period shall apply to Eligible Persons under the age of nineteen (19).

(2) The Effective Date of coverage shall be:

(i) For loss of other coverage or marriage, the first day of the month following the date the Program receives all required forms for enrollment.

(ii) For birth of a Dependent, the date of birth.

(iii) For adoption, the date of adoption or placement for adoption.

(3) Special enrollment applicants must complete the “Acknowledgment of Pre-Existing Condition” form and “Statement of Physical Condition” forms.

(4) Medical expenses incurred during the first twelve (12) months that coverage for the Special Enrollee is in force under this Plan will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the enrollment date. The provisions of this section do not apply to pregnancy or to Dependents under the age of nineteen (19).

(5) If the Special Enrollee was previously covered under a Group Health Plan, Medicare, Medicaid or other creditable coverage as defined in HIPAA, the duration of the prior coverage will be credited against the initial twelve (12) month period used by the Program to exclude benefits for a pre-existing condition if the termination under the prior coverage occurred within sixty-three (63) days of the date of coverage under the Plan.

6. Retirees Special Enrollment

Retirees will not be eligible for special enrollment, except under the following conditions:

a. Retirement began on or after July 1, 1997.

b. The Retiree can document that creditable coverage was in force at the time of the election not to participate or continue participation in the Plan.

c. The Retiree can demonstrate that creditable coverage was maintained continuously from the time of the election until the time of requesting special enrollment.

d. The Retiree has exhausted all COBRA and/or other continuation rights and has made a formal request to enroll within thirty (30) days of the loss of other coverage; and

e. The Retiree has lost eligibility to maintain other coverage through no fault of his own and has no other creditable coverage in effect.

7. Health Maintenance Organization (HMO) Option

   a. In lieu of participating in the Plan, Employees and Retirees may elect coverage under an approved HMO.

   b. New Employees may elect to participate in an HMO during their initial period of eligibility. Each HMO will hold an annual enrollment period for coverage effective date of July 1. Transfer of coverage from the Plan to the HMO or vice-versa will only be allowed during this annual enrollment period.

      (1) Transfer of coverage will be allowed as a result of the Employee being transferred into or out of the HMO geographic service area, with an effective date of the first day of the month following transfer.

   c. If a Covered Person has elected to transfer coverage but is hospitalized on July 1, the Plan providing coverage prior to July 1 will continue to provide coverage up to the date of discharge from the hospital.

8. Medicare Advantage Option for Retirees other than OGB sponsored plans (Effective July 1, 1999)

   Retirees who are eligible to participate in a Medicare Advantage plan who cancel coverage with the Program upon enrollment in a Medicare Advantage plan may re-enroll in the Program upon withdrawal from or termination of coverage in the Medicare Advantage plan, at the earlier of the following:

   a. during the month of November, for coverage effective January 1st; or

   b. during the next annual enrollment, for coverage effective at the beginning of the next Plan Year.

9. 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 Program upon enrollment in TFL may re-enroll in the Program 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 participating employer shall continue to pay its portion of health plan premiums for up to twelve (12) months.

      (2) A participating Employee who suffers a service related injury that meets the definition of a total and permanent disability under the worker's compensation laws of Louisiana may continue coverage and the participating 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 participating employer may continue to pay its portion of premiums.

   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 Paragraph I, may continue to participate in an Office of Group Benefits benefit plan for a period up to twelve (12) months upon the Employee's payment of the full premiums due. THE PROGRAM MUST BE NOTIFIED BY THE EMPLOYEE AND THE PARTICIPANT EMPLOYER WITHIN THIRTY (30) DAYS OF THE EFFECTIVE DATE OF THE LEAVE OF ABSENCE.

2. Disability

   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 or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

      (1) The surviving legal spouse of an Employee or 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 or 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 attainment of the termination age for children, whichever occurs first.

      (3) Surviving dependents will be entitled to receive the same Participant Employer premium contributions as Employees and 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 legal 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 born after the Employee's death.

   c. Participant Employer/Dependent Responsibilities

      (1) It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Program within sixty (60) days of the death of the Employee or Retiree.

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

      (3) Application for continued coverage must be made in writing to the Program 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:

         (i) Failure to pay the applicable premium timely.

         (ii) Eligibility of the surviving dependent child 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:

         (i) Failure to pay the applicable premium timely.

         (ii) Eligibility of the surviving dependent child for coverage under any Group Health Plan other than Medicare; or

         (iii) The attainment of the termination age for children.

   d. The provisions of paragraphs A through C this subsection 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.

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 the coverage for the Dependent Child may be continued for the duration of incapacity.

a. Prior to the Dependent Child reaching age twenty-six (26), an application for continued coverage with current medical information from the Dependent Child's attending Physician must be submitted to the Program to establish eligibility for continued coverage as set forth above.

b. Upon receipt of the application for continued coverage the Program may require additional medical documentation regarding the Dependent Child's mental retardation or physical incapacity as often as it may deem necessary thereafter.

5. Military Leave

Plan Participants of the National Guard or of the United States military reserves who are called to active military duty, and who are OGB Participating Employees or covered Dependents will have access to continued coverage under OGB's health and life plans.

a. Health Plan Participation - When called to active military duty, Participating Employees and covered 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 such plan participants may apply for reinstatement of OGB coverage within thirty (30) days of:

(i) the date of the EMPLOYEE'S re-employment with a participating employer;

(ii) the Dependent's date of discharge from active military duty; or

(iii) the date of termination of extended health coverage provide as a benefit of active military duty, such as TRICARE Reserve Select. Plan participants who elect this option and timely apply for reinstatement of OGB coverage will not be subject to a pre-existing condition (PEC) limitation, and 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. It is the responsibility of the Participant Employer to notify the Program within thirty (30) days of the date coverage would have terminated because of any of the foregoing events and the Program will notify the Employee within fourteen (14) days of his right to continue coverage.

c. Application for continued coverage must be made in writing to the Program within sixty (60) days of the date of the election notification, and premium payment must be made within forty-five (45) days of the

date the Employee elects continued coverage, for coverage 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 premium timely.

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

(3) Entitlement to Medicare.

(4) Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or

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

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 or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.

b. It is the responsibility of the Participant Employer or surviving covered Dependents to notify the Program within thirty (30) days of the death of the Employee or Retiree. The Program will notify the surviving dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Program within sixty (60) days of the date of the election notification.

c. Premium payment must be made 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 premium 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, but only after Pre-Existing Condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or

(5) The Employer ceases to provide any Group Health Plan for its Employees.

3. Divorced Spouse

a. Coverage under this Plan for an Employee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the Employee or Retiree, unless the covered divorced spouse elects to continue coverage at his own expense.

b. It is the responsibility of the divorced spouse to notify the Program within sixty (60) days from the date of divorce, and the Program will notify the divorced spouse within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Program within sixty (60) days of the election notification.

c. 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. 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.

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

(1) Failure to pay the applicable premium 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, but only after any Pre-Existing Condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; 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 of a covered Employee or Retiree 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 elects to continue coverage at his own expense.

b. It is the responsibility of the Dependent to notify the Program within sixty (60) days of the date coverage would have terminated and the Program will notify the Dependent within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Program within sixty (60) days of receipt of the election notification.

c. Premium payment must be made 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 children under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premium 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, but only after any Pre-Existing Condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; 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 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 own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

   b. It is the responsibility of the spouse and/or the dependent child to notify the Program within sixty (60) days of the date COBRA coverage would have terminated.

   c. Monthly payments 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 children under this section will continue until the earliest of the following:

      (1) Failure to pay the applicable premium 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, but only after any pre-existing condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or

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

6. Disability COBRA

   a. If a covered Employee or covered Dependent is determined by the Social Security Administration or by the Program 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 Covered Person became eligible for continued coverage or within the initial eighteen (18) months of coverage, coverage under this Plan for the Covered Person who is totally disabled 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, the Covered Person must:

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

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

         (ii) 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 Program before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the Program 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 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 for each month of extended 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 premium 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, but only after any Pre-Existing Condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person has been exhausted or satisfied.

(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 Program 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 Program 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 premium 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, but only after any pre-existing conditions exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or

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

b. Monthly payments 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

During the period of continuation, benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Employees and Retirees.

9. Special Second Election Period for Certain Trade-Displaced Individuals who did not Elect COBRA Coverage

   Special COBRA rights apply to employees who lost health coverage as a result of a termination or reduction of hours and who qualify for a "trade adjustment allowance (TAA)" or "alternative trade adjustment assistance (ATAA)" under a federal law called the Trade Act of 2002 and as amended by ARRA. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. The sixty (60) day period beginning on the first day of the month in which an eligible employee becomes a TAA or ATAA eligible individual, but only if the election is made within six (6) months immediately after the eligible employee's Group health plan coverage ended. If the Plan Participant qualifies or may qualify for assistance under the Trade Act of 2002, and as amended by ARRA, the Plan Participant should contact the Group's Human Resources Manager for additional information. THE MEMBER MUST CONTACT THE GROUP'S HUMAN RESOURCES MANAGER PROMPTLY AFTER QUALIFYING FOR ASSISTANCE UNDER THE TRADE ACT OF 2002, AND AS AMENDED BY ARRA,OR THE MEMBER WILL LOSE HIS SPECIAL COBRA RIGHTS.

D. Change of Classification

1. Adding or Deleting Dependents

   The Plan Participant must notify the Program when a Dependent is added to or deleted from the Plan Participant's coverage that results in a change in the class of coverage. Notice must be provided within thirty (30) days of the addition or deletion.

2. Change in Coverage

   When there is a change in family status (e.g., marriage, birth of child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for the change must be made within thirty (30) days of the date of the event.

   When the addition of a Dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the fifteenth (15^{th}) day of the month. If the date of change occurs on or after the fifteenth (15^{th}) day of the month, an additional premium will not be charged until the first day of the following month.

3. Notification of Change

   It is the Employee's responsibility to notify the Program of any change in classification of coverage that affects the Employee's contribution amount. If failure to notify is later determined, it will be corrected on the first day of the following month.

E. Contributions

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

F. Medical Child Support Orders

An individual who is a child of a covered Employee 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).

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

1. Provides for support of a covered Employee's child.

2. Provides for health care coverage for that child.

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

4. Relates to Benefits under the Plan; and (e) 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 health care coverage. Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the Plan Administrator.

ARTICLE IV. BENEFITS

ANY BENEFIT LISTED IN THIS PLAN, WHICH IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS. NO BENEFITS ARE AVAILABLE FOR ANY SERVICE THAT REQUIRES AN AUTHORIZATION OR FOR ORGAN, TISSUE AND BONE MARROW TRANSPLANTS OR EVALUATIONS, IF AUTHORIZATION IS NOT RECEIVED PRIOR TO SERVICES BEING RENDERED.

A. Benefit Categories

1. This Benefit Plan includes the following categories of Benefits:

   a. NETWORK BENEFITS: Benefits for Covered Services received from a Network Provider (Providers contracted in the Preferred Care Network or another Blue Plan's PPO Network).

   b. NON-NETWORK BENEFITS: Benefits for Covered Services received from Non-Network Providers (Providers not contracted in the Preferred Care Network or another Blue Plan's PPO Network).

2. Network Benefits:

   a. If a Copayment is shown for a Covered Service, the Plan Participant must pay the applicable Copayment each time the Covered Service is rendered, subject to any limitations or maximum Benefits shown on the Schedule of Benefits.

   b. If a Deductible is shown on the Schedule of Benefits, the Plan Participant must pay the Deductible amount before Benefits will pay for services that are subject to the Deductible. The Deductible does not accrue to the Plan Participant's Out-of-Pocket.

   c. If a Coinsurance is shown for a Covered Service, the Plan Participant must pay any applicable Benefit Period Deductible Amount and that Coinsurance percentage, subject to any limitations or maximum Benefits shown in the Schedule of Benefits. The Claims Administrator will provide Benefits for Covered Services based on the Allowable Charges for those services for which a Coinsurance percentage is applicable.

3. Non-Network Benefits:

   After any Deductible Amounts shown in the Schedule of Benefits have been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Plan will pay the Allowable Charges toward the Covered Services rendered to a Plan Participant during a Benefit Period. The Plan's actual payment to a Provider or payment to the Plan Participant satisfies the Plan's obligation to provide Benefits under this Plan. The Plan Participant may be balance billed by the Provider when services outside the Network are obtained.

4. Under certain circumstances, if the Plan pays the healthcare Provider amounts that are the Plan Participant's responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from the Plan Participant. You agree that the Claims Administrator has the right to collect such amounts from You.

B. Out-of-Pocket Amount

1. The following accrue toward the Out-of-Pocket Amount, as shown in the Schedule of Benefits. After the Plan Participant has met the applicable Out-of- Pocket Amount, the Plan will pay one hundred percent (100%) of the Allowable Charge for the following Covered Services.

   a. any Coinsurance amounts, except those for Organ/Tissue transplants, Durable Medical Equipment, Prosthesis, Orthotics and routine Vision Care if shown as covered in the Schedule of Benefits.

   b. any Copayment amounts, except those for Organ/Tissue transplants, Durable Medical Equipment, Prosthesis, Orthotics and routine Vision Care if shown as covered in the Schedule of Benefits.

2. The following do not apply toward satisfying the Out-of-Pocket Amount:

   a. Deductible Amounts.

   b. any charges in excess of the Allowable Charge.

   c. any penalties the Plan Participant or Provider must pay.

   d. charges for Organ/Tissue transplants, Durable Medical Equipment, Prosthesis, Orthotics and routine Vision Care; and/or charges for non-covered services.

C. Deductible Amount

The Claims Administrator will apply the Plan Participant's Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by the Claims Administrator. The Claims Administrator's system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays his Deductible Amount, the Plan Participant is entitled to receive a refund from the Provider to whom the overpayment was made.

D. Accumulator Transfers

Plan Participants' needs sometimes require that they transfer from one of the Group's Plans to another. Plan Participant's accumulators may be carried from the old Plan to the new Plan. Accumulators include, but are not limited to, Deductibles, Out-of-Pocket Amounts and Benefit Period Maximums.

ARTICLE V. HOSPITAL BENEFITS

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

If a Plan Participant receives services from a Physician in a Hospital-based clinic, the Plan Participant may be subject to charges from the Physician and/or clinic as well as the facility. The following services furnished to a Plan Participant by a Hospital are covered:

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.

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

3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital, for the maximum number of days per Benefit Period shown in the Schedule of Benefits.

4. In a Residential Treatment Center, subject to the limitations as set forth in this Benefit Plan.

B. Other Hospital Services (Inpatient and Outpatient)

1. Use of operating, delivery, recovery and treatment rooms and equipment.

2. Drugs and medicines including take-home Prescription Drugs.

3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.

4. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital Employee.

5. Medical and surgical supplies, casts, and splints.

6. Diagnostic Services rendered by a Hospital Employee.

7. Physical Therapy provided by a Hospital Employee.

8. Psychological testing when ordered by the attending Physician and performed by an Employee of the Hospital.

C. Emergency Room

The Plan Participant may have to pay applicable Copayment, Deductible and/or Coinsurance Amounts as shown in the Schedule of Benefits, for each visit to an Emergency room for treatment. The Emergency room Copayment is waived if an Emergency visit results in an Inpatient Admission. If the Plan Participant receives treatment from a Non-Network facility and the Plan Participant's condition is an Emergency as defined in the Definitions Article of this Benefit Plan, Benefits will be paid at the In-Network level.

D. Pre-Admission Testing

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

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

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

A. Surgical Services

1. Surgery

   a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by the

Claims Administrator and is that period of time which is appropriate as routine care for the particular surgical procedure.

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

2. Multiple Surgical Procedures - When Medically Necessary multiple procedures (concurrent, successive, or other multiple surgical procedures) are performed at the same surgical setting, Benefits will be paid as follows:

   a. Primary Procedure

      (1) The primary or major procedure will be the procedure with the greatest value based on the Allowable Charge.

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

   b. Secondary Procedure(s)

      The secondary procedure(s) is a procedure(s) performed in addition to the primary procedure which adds significant time, risk, or complexity to the Surgery. The Allowable Charge for the secondary procedure will be based on a percentage of the Allowable Charge that would be applied had the secondary procedure been the primary procedure.

   c. Incidental Procedure

      (1) An incidental procedure is one carried out at the same time as a more complex primary procedure and which requires little additional Physician resources and/or is clinically integral to the performance of the primary procedure.

      (2) The Allowable Charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

   d. Unbundled Procedure(s)

      (1) Unbundling occurs when two (2) or more procedure codes are used to describe Surgery performed when a single, more comprehensive procedure code exists that accurately describes the entire Surgery performed. The unbundled procedures will be rebundled for assignment of the proper comprehensive procedure code as determined by the Claims Administrator.

      (2) The Allowable Charge includes the rebundled procedure. The Claims Administrator will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as the Claims Administrator determines.

   e. Mutually Exclusive Procedure(s)

      (1) Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made.

      (2) The Allowable Charge includes all procedures performed at the same surgical setting. Procedure(s), which are not considered Medically Necessary, will not be covered.

3. Assistant Surgeon

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

4. Anesthesia

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

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

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

5. Second Surgical Opinion

   Second surgical opinions are covered, subject to any applicable Copayments, Coinsurance and Deductible Amounts, but are not mandatory in order to receive Benefits.

B. Inpatient Medical Services - Subject to provisions in the sections pertaining to Surgery and Pregnancy Care in this Benefit Plan, Inpatient Medical Services include:

1. Inpatient medical care visits

2. Concurrent Care

3. Consultation (as defined in this Benefit Plan)

C. Outpatient Medical and Surgical Services

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

2. Services of an Ambulatory Surgical Center

3. Consultation (as defined in this Benefit Plan)

ARTICLE VII. PRESCRIPTION DRUG BENEFITS (Medical Benefit)

Blue Cross and Blue Shield of Louisiana provides claims payment services ONLY for those Prescription Drugs administered during an Inpatient or Outpatient stay and those medically necessary/non-investigational drugs requiring parenteral administration in a physician's office. Additionally, drugs that can be self-administered that are provided to a Plan Participant in a physician's office are payable under this medical Benefit.

Blue Cross and Blue Shield of Louisiana does not provide claims payment services for drugs purchased at a pharmacy. These drugs and others are payable under the Pharmacy Benefits that are provided by OGB's Pharmacy Benefit Administrator. See the Schedule of Benefits for more information.

ARTICLE VIII. PREVENTIVE OR WELLNESS (ROUTINE) CARE

The Plan Participant must pay all Copayments, Deductible and Coinsurance as shown on the Schedule of Benefits. Preventive services in the following categories are covered at no cost to the Plan Participant when services are obtained from a Network Provider. In-Network Physician office visits are covered at no cost to the Plan Participant when required by law. You will have to pay all Copayments, Deductible and/or Coinsurance when receiving these Benefits from a Provider who is not in Your Network.

A. Well Woman Diagnostic Testing

1. Mammograms (includes office visit, Outpatient or freestanding facility).

    a. One baseline mammogram for a Covered Person who is age thirty-five (35) through age thirty-nine (39) years of age.

    b. One mammogram every twenty-four (24) months for Covered Person who is age forty (40) through age forty-nine (49) or more frequently if recommended by Physician.

    c. One mammogram every twelve (12) months for a Covered Person who is age fifty (50) or older.

    NOTE: If mammograms are deemed medically necessary beyond those stated above, no age or timeline limitations will apply.

2. Routine Pap smear.

B. Immunizations

1. Immunizations recommended by the Plan Participant's Physician.

2. Flu/Pneumonia immunizations (See the Schedule of Benefits for more information).

C. Vaccinations

1. Gardasil/Human Papillomavirus Vaccine (HPV) for Covered Persons.

2. Shingles Vaccine (i.e. Zostavax) for Covered Persons.

3. Meningitis Vaccine for Covered Persons.

D. Other Wellness Services

1. Routine exams.

2. Prostate antigen testing; includes office visit, Outpatient or freestanding laboratory.

3. Hemoccult (colon) test.

4. Routine hearing exams and testing.

5. Preventive endoscopic services.

6. Routine cancer screenings (colonoscopy, sigmoidoscopy and proctosigmoidoscopy); includes office visit, Outpatient or freestanding laboratory.

7. Health education programs (Lamaze and Diabetic education and training.).

8. Routine x-ray and laboratory tests ordered by Your Physician are covered. Examples of these routine wellness diagnostic tests that would pay under this Preventive and Wellness Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels. Higher tech services such as an MRI, MRA, SPECT scan, CT scan, CAT scan, PET scan, nuclear cardiology, are not covered under this Preventive and Wellness Benefit. These higher tech services are covered under standard contract Benefits when the tests are Medically Necessary. See the Schedule of Benefits for more information.

9. Well Baby Care.

E. Preventive Services Covered under the Affordable Care Act

Preventive services in the following categories, referred to as "Recommended Preventive Services," are covered at no cost to the Plan Participant when services are obtained from a Network Provider. In-Network Physician office visits are covered at no cost to the Plan Participant when required by law.

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

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

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

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

Specific Preventive or Wellness Care services may be included or excluded from this Benefit if shown in the Schedule of Benefits.

ADULTS – COVERED PREVENTIVE SERVICES

- Abdominal Aortic Aneurysm - one-time screening for men of specified ages who have ever smoked;
- Alcohol Misuse Screening and Counseling;
- Aspirin use for men and women of certain ages;
- Blood Pressure Screening;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal Cancer Screening for adults over the age of fifty (50);
- Depression Screening;
- Type 2 Diabetes screening for adults with high blood pressure;
- Diet Counseling for adults at higher risk for chronic disease;
- HIV Screening for all adults at higher risk;

- Immunization vaccines for adults; doses, recommended ages and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Dephtheria, Pertussis
    - Varicella
- Obesity Screening and Counseling;
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risks;
- Tobacco Use Screening for all adults and cessation interventions for tobacco users;
- Syphilis screening for all adults at higher risk.

WOMEN, INCLUDING PREGNANT WOMEN – COVERED PREVENTIVE SERVICES

- Anemia Screening on a routine basis for pregnant women;
- Bacteriuria urinary tract or other infection screening for pregnant women;
- BRCA Counseling about genetic testing for women at higher risk;
- Breast Cancer Mammography Screenings every 1 to 2 years for women over the age of forty (40);
- Breast Feeding interventions to support and promote breast feeding;
- Cervical Cancer Screening;
- Chlamydia Infection Screening for younger women and other women at higher risk;
- Folic Acid supplements for women who may become pregnant;
- Gonorrhea Screening for all women at higher risk;
- Hepatitis B Screening for pregnant women at their first prenatal visit;
- Osteoporosis Screening for women over the age of sixty (60) depending on risk factors;
- Rh Incompatibility Screening for all pregnant women and follow-up testing for women at higher risk;
- Tobacco Use Screening and interventions, and expanded counseling for pregnant tobacco users;
- Syphilis screening for all pregnant women or other women at increased risk.

CHILDREN – COVERED PREVENTIVE SERVICES

- Alcohol and Drug Use assessments for adolescents;
- Autism Screening for children ages one (1) and two (2) years;
- Behavioral Assessments for children of all ages;

- Cervical Dysplasia Screening for sexually active females;
- Congenital Hypothyroidism Screening for newborns;
- Developmental Screening for children under the age of three (3), and surveillance throughout childhood;
- Dyslipidemia Screening for children at higher risk of lipid disorders;
- Fluoride Chemoprevention supplements for children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing Screening for all newborns;
- Height, Weight and Body Mass Index measurements;
- Hematocrit or Hemoglobin Screening;
- Hemoglobinopathies or sickle cell screening for newborns;
- HIV for adolescents at higher risk;
- Immunization vaccines:
    - Diphtheria, Tetanus, Pertusses
    - Haemophilus influenza type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
- Iron supplements for children ages six (6) to twelve (12) months;
- Lead Screening for children at risk of exposure;
- Medical History for all children throughout development;
- Obesity Screening and Counseling;
- Oral Health risk assessment for young children;
- Phenylketonuria (PKU) Screening for this genetic disorder in newborns;
- Sexually Transmitted Infections prevention counseling for adolescents at higher risk;
- Tuberculin testing for children at higher risk of tuberculosis;
- Vision Screening.

ARTICLE IX. MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Mental Health services (Medical Visit Only) rendered by a Non-Psychiatric Provider are limited to the initial visit only, and are subject to the Copayment, Deductible and Coinsurance shown on the Schedule of Benefits. Copayment amount depends on type of Non-Psychiatric Provider (primary care physician or specialist). This limitation does not apply to the treatment of the following:

- Attention Deficit Disorder
- Autism
- Attention Deficit Hyperactivity Disorder
- Tourette's Syndrome
- Bulimia
- Anorexia
- Applied Behavioral Analysis (ABA)

Refer to the Schedule of Benefits for more information on Mental Health and substance abuse Benefits.

ARTICLE X. ORAL SURGERY BENEFITS

Coverage is provided only for the following services or procedures: The highest level of Benefits is available when services are performed by a Network Provider, or by a Provider in Blue Cross and Blue Shield of Louisiana's dental network. Access the dental network online at **www.bcbsla.com**, or call the customer service telephone number on Your ID card for a copy of the directory.

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

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

C. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.) Services must begin within ninety (90) days of the accidental injury and be completed within twenty-four (24) months after the date of injury.

D. Reduction of fractures and dislocations of the jaw.

E. External incision and drainage of cellulitis.

F. Incision of accessory sinuses, salivary glands or ducts.

G. Splint therapy for the treatment of Temporomandibular Joint dysfunction (TMJ) repair; limited to a maximum six-hundred ($600.00) dollar Lifetime Benefit.

H. Frenectomy (the cutting of the tissue in the midline of the tongue).

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

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

K. Anesthesia when rendered in a Hospital or Outpatient facility setting and for associated Hospital charges when a Plan Participant's mental or physical condition requires dental treatment to be rendered in a Hospital or Outpatient facility setting. Anesthesia Benefits are available for treatment rendered for TMJ Disorders.

L. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To determine if the Plan Participant is eligible for these Benefits, please call the Plan's customer service unit at the telephone number on the Plan Participant's ID card, and ask to speak to a Case Manager.

ARTICLE XI. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

(Benefits available from Network Providers only)

OUR AUTHORIZATION IS REQUIRED FOR THE EVALUATION OF A MEMBER'S SUITABILITY FOR ALL SOLID ORGAN AND BONE MARROW TRANSPLANT PROCEDURES. FOR THE PURPOSES OF COVERAGE UNDER THIS BENEFIT PLAN, ALL AUTOLOGOUS PROCEDURES ARE CONSIDERED TRANSPLANTS UNLESS OTHERWISE STATED.

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

A. Donor Costs/Expenses

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

B. Organ, Tissue and Bone Marrow Transplants

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) or a Blue Cross and Blue Shield of Louisiana (BCBSLA) Network facility, unless otherwise approved by the Claims Administrator in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities. To locate an approved transplant facility, Plan Participants should contact the Plan's customer service department at the number listed on their ID card.

2. The Organ, Tissue and Bone Marrow Transplant Benefits are shown in the Schedule of Benefits and are not covered under the Non-Network Benefit category.

3. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs administered for transplant procedure(s). No Benefits are available under this Benefit Plan for immunosuppressive drugs received after an Inpatient Admission ends.

Benefits as specified in this section will be provided for treatment and care because of or directly related to the following transplant procedures:

C. Solid Human Organ Transplants of the:

1. liver;

2. heart;

3. lung;

4. kidney;

5. pancreas;

6. small bowel; and

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

D. Tissue Transplant Procedures (Autologous and Allogeneic)

The following tissue transplants (other than bone marrow) are covered under regular Benefits and do not require prior Authorization. However, if an Inpatient Admission is required, it is subject to the Article on Authorization of Services and Supplies.

These following tissue transplants are covered:

1. blood transfusions

2. autologous parathyroid transplants

3. corneal transplants

4. bone and cartilage grafting

5. skin grafting

6. autologous islet cell transplants

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

E. Bone Marrow Transplants

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

2. The storage of autologous bone marrow is covered for a period not to exceed thirty (30) days.

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

F. Temporary Lodging

Direct, non-medical costs for the Covered Person will be paid for temporary lodging at a prearranged location up to a fifty ($50.00) dollar per diem, when requested by the Hospital and approved by the Plan.

ARTICLE XII. PREGNANCY AND NEWBORN CARE BENEFITS

A. Pregnancy Care

Pregnancy Care is a covered expense for a Plan Participant or dependent wife of a Plan Participant only. Benefits for complications of pregnancy are available for all Covered Persons, including dependent daughters.

Benefits for ectopic pregnancies and spontaneous abortions (miscarriages) are available for all Covered Persons under Articles IV and V of this Benefit Plan the same as any other Covered Service, and are not subject to this Article.

If Pregnancy Care is covered, Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a patient covered as a Plan Participant or Dependent wife of a Plan Participant whose coverage is in effect at the time such services are furnished in connection with her pregnancy. An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a newborn's stay exceeds that of the mother. An Authorization is also required for a newborn that is admitted separately because of neonatal complications. Pregnancy Care Benefits are as follows:

1. Medical and Surgical Services

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

   b. Diagnostic Services.

   c. Delivery, including necessary pre-natal and post-natal care.

   d. Medically Necessary abortion under the following circumstances:

      (1) the pregnancy would endanger the life of the mother; or

      (2) the pregnancy is a result of rape or incest; or

      (3) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

2. Facility Services

   Hospital services required in connection with pregnancy and Medically Necessary abortions as described above.

3. Pregnancy Care Copayment, Deductible, Coinsurance

   A Pregnancy Care Copayment, if shown in the Schedule of Benefits, applies to Covered Services rendered by Network Providers, for each covered pregnancy. The Plan Participant must pay all applicable Hospital Copayments, Deductibles and/or Coinsurance for any hospitalization related to the pregnancy, as shown in the Schedule of Benefits, in addition to any applicable Pregnancy Care Copayments. A Plan Participant obtaining care from a Non-Network Provider must pay the Hospital Deductible and Coinsurance and any Pregnancy Care Deductible and Coinsurance, if shown in the Schedule of Benefits.

4. Statement of Rights under the Newborns' and Mothers' Health Protection Act

   Under federal law, Group health plans and health insurance issuers offering Group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your physician, certified nurse midwife, or physician assistant), after Consultation with the mother, discharges the mother or Newborn earlier. Also, under federal law, plans and issuers may not set the level of Benefits or Out-of-Pocket costs so that any later portion of the

48-hour or 96-hour stay is treated in a manner less favorable to the mother or Newborn than any earlier portion of the stay.

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

B. Newborn Care

For a newborn that is covered at birth as a Dependent, covered expenses incurred during a newborn child's initial Inpatient hospital stay include:

1. Hospital nursery charges;

2. Medical and Surgical services rendered by a Physician, for treatment of illness, prematurity, postmaturity, or congenital condition of a newborn and circumcision; and

3. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, prematurity, post maturity, or congenital condition of a newborn.

   In Inpatient Hospital Admission Copayment applies to the Admission of an ill/sick newborn for treatment in a Network Hospital. The Plan will provide Benefits of one hundred percent (100%) of the Allowable Charges for such treatment, less the Plan Participant's Copayment. Benefits for Hospital Covered Services for treatment of an ill newborn at a Non-Network Hospital will be determined by applying the Deductible and Coinsurance shown in the Schedule of Benefits to Allowable Charges for those services.

ARTICLE XIII. REHABILITATIVE CARE BENEFITS

Rehabilitative Care Benefits will be available for Services provided on an Inpatient or Outpatient basis, including services for hearing therapy, cognitive therapy, Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, and/or Chiropractic Services. Benefits are available when services are rendered by a Provider licensed and practicing within the scope of his license. The Plan Participant must be able to tolerate a minimum of three (3) hours of active therapy per day.

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

Day Rehabilitation programs for Rehabilitative Care may be Authorized in place of Inpatient stays for rehabilitation. Day Rehabilitation programs must be Authorized prior to beginning the program and must begin within seventy-two (72) hours following discharge from an Inpatient Admission for the same or similar condition.

A. Occupational Therapy

1. Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his license, including but not limited to a licensed occupational therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.

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

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

B. Physical Therapy

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license.

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

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

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

    a. to children with a diagnosed developmental disability pursuant to the patient's plan of care;

    b. as part of a Home Health Care agency pursuant to the patient's plan of care;

    c. to a patient in a nursing home pursuant to the patient's plan of care;

    d. related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness;

    e. to an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the health care Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the health care Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are only covered for sickness and injury.

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

3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to the receipt of services.

4. Authorization is required prior to the receipt of Speech/Language Pathology Therapy services.

D. Hearing Therapy

Benefits are available under this Plan for hearing therapy. Refer to the Schedule of Benefits for more information.

E. Cognitive Therapy

Benefits are available under this Plan for cognitive therapy. Refer to the Schedule of Benefits for more information.

F. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.

2. Chiropractic Services are not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Maintenance therapy is not covered except for periodic visits to reinforce any need for therapy or current therapeutic objectives.

3. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for the rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

ARTICLE XIV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

The following services are available to a Plan Participant. The Plan Participant must pay all Copayments, applicable Deductible Amounts and Coinsurance percentages. These services, supplies or equipment may also be subject to other limitations shown in the Schedule of Benefits.

A. Acupuncture

This is a covered Benefit when:

1. the treatment is medically necessary and appropriate and is provided within the scope of the acupuncturist's license; or

2. the services are performed by a licensed physician; and

3. the acupuncture is performed in lieu of generally accepted anesthesia practices.

B. Acute Detoxification

Benefits are available for the medical treatment of acute detoxification resulting from substance abuse.

C. Ambulance Services

Medically necessary ambulance services to or from a hospital with facilities to treat an injury or illness are covered. All other ambulance services must be for emergency medical transportation only and must not be provided primarily for the convenience of the patient. In a non-emergency situation, air and ground ambulance services are not covered.

1. The following Ambulance Services for local transportation are covered when Medically Necessary:

   a. to or from the nearest Hospital that can provide services appropriate to a Plan Participant's condition for an illness or injury requiring Hospital care;

   b. to the nearest Hospital or neonatal Special Care Unit for newborn infants for treatment of illnesses, injuries, congenital birth defects and complications of premature birth which require that level of care;

   c. for the Temporarily Medically-Disabled Mother of the ill Newly-Born Infant when accompanying the ill Newly-Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.

2. Benefits for air Ambulance Services are available only if this type of Ambulance Service is requested by policing or medical authorities at the site in an Emergency situation or if the Plan Participant is in a location that cannot be reached by a ground ambulance.

3. In a non-emergency situation, air and ground Ambulance Services are not covered.

4. If a Plan Participant pays a periodic fee to an ambulance membership organization with which the Claims Administrator does not have a Provider Agreement, Benefits for expenses that the Plan Participant incurs for Ambulance Services will be based on any obligation the Plan Participant must pay that is not covered by the fee.

5. No Benefits are available if transportation is provided for the Plan Participant's comfort or convenience, or when a Hospital transports Plan Participants between parts of its own campus.

D. Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder when rendered or prescribed by a Non-Psychiatric Provider is covered the same as any other illness.

E. Autism Spectrum Disorders (ASD)

ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Plan Participants who have not yet reached their seventeenth (17^{th}) birthday are eligible for Applied Behavior Analysis, when Company determines it is Medically Necessary. Applied Behavior Analysis is not covered for Plan Participants age seventeen (17) and older.

ASD Benefits are subject to the Copayments, Deductibles, and Coinsurance amounts that are applicable to the Benefits obtained. Example: A Plan Participant obtains Speech Therapy for treatment of ASD. The Plan Participant will pay the applicable Copayment, Deductible or Coinsurance amount shown on the Schedule of Benefits for Speech Therapy.

F. Bone Mass Measurement

Benefits are available for scientifically proven non-routine Bone Mass Measurement tests for the diagnosis and treatment of osteoporosis if a Plan Participant:

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

2. is an individual receiving long-term steroid therapy; or

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

Deductible, Coinsurance and/or Copayment amounts may be applicable.

G. Breast Reconstructive Surgical Services

Breast Reconstructive Surgical Services shall be delivered in a manner determined in Consultation with the Plan Participant and the Plan Participant's attending Physician, if applicable, and will be subject to any Deductible Amounts, Copayments and Coinsurance.

1. If a Plan Participant is receiving Benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy, the Plan Participant will also receive Benefits for the following Covered Services:

    a. reconstruction of the breast on which the mastectomy has been performed;

    b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. prostheses and physical complications of all states of mastectomy, including lymphedermas.

2. Reduction mammaplasty is a Covered Service WHEN MEDICALLY NECESSARY for treatment of one or more of the following physical symptoms resulting from macromastia:

   a. back, neck or shoulder pain;

   b. decrease in normal routine physical activity;

   c. paresthesia of hands or arms in ulnar distribution;

   d. permanent shoulder grooves from bra strap; and/or

   e. poor posture as a result of breast size.

H. Cleft Lip and Cleft Palate Services

Covered Services include the following:

1. Oral and facial Surgery, surgical management, and follow-up care.

2. Prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

3. Orthodontic treatment and management.

4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

5. Speech-language evaluation and therapy.

6. Audiological assessments and amplification devices.

7. Otolaryngology treatment and management.

8. Psychological assessment and counseling.

9. Genetic assessment and counseling for patient and parents.

I. Clinical Trial Participation

1. Patient costs are covered when incurred for treatment provided in a clinical trial for cancer, as described in this paragraph. Coverage will be subject to any applicable Copayment, Deductible, or Coinsurance amounts shown in the Schedule of Benefits.

2. The following services are not covered:

   a. non-healthcare services provided as part of the clinical trial;

   b. costs for managing research data associated with the clinical trial;

   c. Investigational drugs or devices; and/or

   d. services, treatment or supplies not otherwise covered under this Plan.

3. Investigational treatments and associated protocol related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:

   a. the treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer;

b. the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer;

c. the treatment is being provided in accordance with a clinical trial approved by one of the following entities:

(1) one of the United States National Institutes of Health;

(2) a cooperative Group funded by one of the National Institutes of Health;

(3) the FDA, in the form of an Investigational new drug application;

(4) the United States Department of Veterans Affairs;

(5) the United States Department of Defense;

(6) a federally funded general clinical research center;

(7) the Coalition of National Cancer Cooperative Groups.

d. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.

e. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

f. There must be no clearly superior, non-investigational approach.

g. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.

h. The patient has signed an institutional review board approved consent form.

J. Colorectal Cancer Screening

Benefits are available for routine colorectal cancer screenings. Routine colorectal cancer screening shall mean a fecal occult blood test, flexible sigmoidoscopy, or colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by the Plan to be Investigational.

K. Complications

Services performed as a result of a complication are covered, regardless of whether the original service was a covered Benefit under the Plan.

L. Diabetic Coverage - Education, Training and Supplies

1. Coverage is available for the equipment and Outpatient self-treatment training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Plan Participant's Physician.

2. Plan Participant evaluation and training for diabetes self-management is covered, subject to the following:

    a. The program must be determined to be Medically Necessary by a Physician and provided by a licensed health care professional that certifies that a Plan Participant has successfully completed the training program.

    b. The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

3. Diabetic supplies are only covered when billed by a medical Provider.

M. Disposable Medical Equipment or Supplies

Blue Cross and Blue Shield of Louisiana provides claim payment services for Disposable Medical Equipment and Supplies provided by a medical Provider only when medically necessary.

N. Durable Medical Equipment, Orthotic Devices, Prosthetic Appliances and Devices

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered at the Coinsurance percentages shown in the Schedule of Benefits.

1. Durable Medical Equipment

    a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be provided mainly for the comfort or convenience of the Plan Participant or others. In addition, the equipment must meet all of the following criteria:

        (1) it must withstand repeated use;

        (2) it is primarily and customarily used to serve a medical purpose;

        (3) it is generally not useful to a person in the absence of illness or injury; and

        (4) it is appropriate for use in the patient's home.

    b. Benefits for rental or purchase of Durable Medical Equipment.

        (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge);

        (2) at the Claims Administrator’s option, on behalf of the Group, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge;

        (3) Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Plan Participant selects deluxe equipment solely for his comfort or convenience;

        (4) Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary;

        (5) accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately;

        (6) repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or damaged due to neglect or misuse or for replacement of equipment within five (5) years of purchase or rental will not be covered.

c. Limitations in connection with Durable Medical Equipment.

(1) there is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier;

(2) there is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose;

(3) there is no coverage for repair or replacement of equipment lost or damaged due to neglect or misuse;

(4) reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by the Plan.

2. Orthotic Devices

Benefits as specified in this section will be available for the purchase of Orthotic Devices Authorized by the Claims Administrator. These Benefits will be subject to the following:

a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.

b. Repair or replacement of the Orthotic Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. The Claims Administrator will determine this time period.

c. Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when a Plan Participant selects a deluxe device solely for his comfort or convenience.

d. Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented to be Medically Necessary.

e. No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease or hammertoe.

3. Prosthetic Appliances, Devices and Prosthetic Services of the Limbs (Non-Limb and Limb)

Benefits will be available for the purchase of Prosthetic Appliances, Devices and Prosthetic Services that the Claims Administrator Authorizes and are covered subject to the following:

a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.

b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Claims Administrator will determine this time period.

c. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.

d. Mastectomy bras, limited to 2 (two) per Plan Year.

e. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience. A Plan Participant may choose a Prosthetic Appliance or Device that is priced higher than the benefit payable under this Benefit Plan and may pay the difference between the price of the device and the benefit payable, without financial or contractual penalty to the provider of the device.

f. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

O. Emergency Medical Services

A Plan Participant must pay an Emergency room Copayment, shown in the Schedule of Benefits, for each visit the Plan Participant makes to a Hospital or Allied Health Facility for Emergency Medical Services. The Emergency room Copayment is waived if the visit results in an Inpatient Hospital Admission. A Plan Participant must pay a Physician's Copayment for each visit the Plan Participant makes to a Physician's office for Emergency Medical Services. See the Hospital Benefits Article in this Benefit Plan for more information on Emergency Room Benefits.

P. Hearing Aids – Network Benefits Only

Benefits are available for hearing aids for covered Plan Participants age seventeen (17) and under. This Benefit is limited to one hearing aid, per ear, in a thirty-six (36) month period. The hearing aid must be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

The Plan will pay up to the Allowable Charge for this Benefit. The Plan may increase its Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge. In no event will the Plan pay more than one thousand, four hundred dollars ($1,400.00) per hearing aid, per ear, in a thirty-six (36) month period. If the Plan Participant purchases a hearing aid that costs more than one thousand, four hundred dollars ($1,400.00), the Plan Participant is responsible for all amounts above one thousand, four hundred dollars ($1,400.00). A hearing aid shall mean a non-disposable device that is designed to optimize audibility and listening skills.

Eligible implantable bone conduction hearing aids are not subject to the above limitation and provisions. They are covered the same as any other service or supply, subject to any applicable Copayment, Coinsurance and Deductible Amounts.

Q. Hospice and Home Health Care (*These services are non-covered Benefits when Medicare is primary.)*

1. Hospice Care is a covered Benefit under this Plan. See the Schedule of Benefits for more information.

2. Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered, for the maximum number of visits per Benefit Period shown in the Schedule of Benefits.

R. Infertility Treatment

Treatment of Infertility is not covered; only the first office visit for the initial diagnosis of Infertility is covered. Services are limited to one (1) initial office visit. See the Schedule of Benefits for more information.

S. Interpreter Expenses for the Hearing Impaired – Network Benefits Only

Services performed by an In-Network qualified interpreter/transliterator are covered at one-hundred percent (100%) of the allowable charge when the Plan Participant needs such services in connection with medical treatment or diagnostic consultations performed by a Physician or Allied Health Professional, if the services are required because of the Plan Participant's hearing impairment or his failure to understand or otherwise communicate in spoken language. Services rendered by a family member are not covered.

T. Pain Management Programs

Pain rehabilitation control and/or therapy designed to develop an individual's ability to control or tolerate chronic pain.

U. Permanent Sterilization Procedures

Benefits are available for surgical procedures and/or contraceptive devices that result in permanent sterilization, including tubal ligation, vasectomy, and hysteroscopic placement of micro-inserts into the fallopian tubes.

V. Sleep Studies

Medically Necessary sleep studies and associated professional Claims are eligible for coverage when a sleep study is obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM).

W. Urgent Care Center

An Urgent Care Center Copayment, shown in the Schedule of Benefits, applies to each visit to an Urgent Care Center that is in the Network. A Plan Participant receiving care from a Non-Network Urgent Care Center is responsible for the Deductible and Coinsurance percentage shown in the Schedule of Benefits subject to any limitations.

X. Vision Care

1. One (1) routine eye examination/eye refraction per Plan Year as shown in the Schedule of Benefits. A Plan Participant must pay the Vision Care Copayment shown in the Schedule of Benefits. These services are non-covered when Medicare is primary.

2. Non-routine Vision Care exams are subject to the Copayment, Deductible and Coinsurance amounts shown on the Schedule of Benefits.

3. Benefits are available for eyeglass frames and one pair of eyeglass lenses or one pair of contact lenses required as a result of cataract surgery and purchased within six (6) months following the cataract surgery. Expenses incurred for the eyeglass frames will be limited to a maximum benefit of fifty dollars ($50.00).

ARTICLE XV. CARE MANAGEMENT

A. Authorization of Services and Supplies

IF AUTHORIZATION IS NOT OBTAINED PRIOR TO SERVICES BEING RENDERED, SERVICES ARE NOT COVERED.

1. Authorization of Admissions

   a. Authorization of Elective Admissions

      (1) The Plan Participant is responsible for ensuring that his Provider contacts the Plan's Care Management Department of any Elective or non-emergency Inpatient Hospital Admission. The Company must be notified (by calling the telephone number shown in the Schedule of Benefits or the Plan Participant's ID card) prior to the Admission regarding the nature and purpose of any Elective Admission or non-emergency Admission to a Hospital's Inpatient department. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.

      (2) If Authorization is not requested prior to the services being rendered, the Plan Participant will be responsible for (and no Benefits will be payable for) charges incurred for Hospital services during the Admission.

      (3) If a request for Authorization is denied, the Admission is not covered and the Plan Participant must pay ALL charges incurred for Hospital services during the Admission for which Authorization was denied.

(4) Additional amounts for which the Plan Participant is responsible because Authorization of an Elective or non-emergency Inpatient Hospital Admission was denied or not requested will not apply toward satisfying the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

(1) It is the Plan Participant's responsibility to ensure that his Physician or Hospital, or a representative thereof, notifies the Company's Care Management Department of all Emergency Inpatient Hospital Admissions to guarantee coverage. Within forty-eight (48) hours of the Emergency Admission, the Company must be notified (by calling the telephone number shown in the Schedule of Benefits or the Plan Participant's ID card) regarding the nature and purpose of the Emergency Admission. The Company may waive or extend this time limitation if it determines that the Plan Participant is unable to timely notify or direct his representative to notify the Company of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend the Company must be notified on its next working day. The appropriate length of stay for the Emergency Admission will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.

(2) If Authorization is not requested prior to the services being rendered, the Plan Participant will be responsible for (and no Benefits will be payable for) charges incurred for Hospital services during the Admission.

(3) If Authorization is denied, the Admission will not be covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission.

(4) Additional amounts the Plan Participant is responsible for because Authorization of an Emergency Admission was denied or not requested will not apply toward the Out-of-Pocket Amount.

c. Concurrent Review

(1) When the Company Authorizes a Plan Participant's Inpatient stay, the Company will Authorize his stay in the Hospital for a certain number of days. If the Plan Participant has not been discharged on or before the last Authorized day, and the Plan Participant needs additional days to be Authorized, the Plan Participant must make sure his Physician or Hospital contacts the Company's Care Management Department to request Concurrent Review for Authorization of additional days. This request for continued hospitalization must be made on or before the Plan Participant's last Authorized day so the Company can review and respond to the request that day. If the Company Authorized the request, the Company will again Authorize a certain number of days, repeating this procedure until the Plan Participant is either discharged or the Plan Participant's continued stay request is denied.

(2) If the Company does not receive a request for Authorization for continued stay on or before the Plan Participant's last Authorized day, no days are approved past the last Authorized day, and no additional Benefits will be paid unless the Company receives and authorizes another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and the Company determines that it is not Medically Necessary for the Plan Participant to receive continued hospitalization or hospitalization at the level of care requested, the Company will notify the Plan Participant and his Providers, in writing, that the request is denied and no additional days are Authorized.

(3) If the Company denies a Concurrent Review request or level of care request for Hospital Services, the Company will notify the Plan Participant, his Physician and the Hospital of the denial. If the Plan Participant elects to remain in the Hospital as an Inpatient thereafter, or at the same level of care, the Plan Participant will not be responsible for any charges unless he is notified of his financial responsibility by the Physician or Hospital in advance of incurring additional charges.

(4) Charges for non-authorized days in the Hospital that the Plan Participant must pay will not apply toward satisfying the Out-of-Pocket Amount.

2. Authorization of Outpatient Services, Including Other Covered Services and Supplies

   Certain services and supplies require the Claims Administrator's Authorization before a Plan Participant receives the services and supplies. The Authorizations list is shown in the Plan Participant's Schedule of Benefits. The Plan Participant is responsible for making sure his Provider obtains all required Authorizations for him before he receives the services or supplies. If Authorization is not requested prior to a listed service being rendered or a listed supply being received, the Plan Participant will be responsible for (and no Benefits will be payable for) charges incurred. The Claims Administrator may need the Plan Participant's Provider to submit medical or clinical information about the Plan Participant's condition. To obtain Authorizations, the Plan Participant's Provider should contact the Claims Administrator's Care Management Department at 1-800-523-6435 or at the telephone number shown on the Plan Participant's ID card.

3. Appeals

   a. If either the Plan Participant or the Provider disagrees with the denial of any Authorization, the denial may be appealed as shown in the Complaints, Grievance and Appeals article of this Benefit Plan. The Plan Participant or the Provider may Appeal the denial by contacting the Company in writing within one hundred eighty (180) days of notice of the denial in accordance with the Complaints, Grievance and Appeals article of this Benefit Plan.

   b. If the Company does not reverse the decision, the Plan Participant will be responsible for (and no Benefits will be payable for) charges incurred.

   c. Providers will be notified of Appeal results only if the Provider filed the Appeal.

B. Disease Management

OGB's Disease Management programs are committed to improving the quality of care for its Blue Cross Blue Shield of LA HMO Plan Participants as well as decreasing health care costs in populations with one or more of these five (5) chronic health conditions – diabetes, heart disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). The *Living Well Louisiana* disease management program is administered by Nurtur Health. This program offers professional health coaches who work with Plan Participants to help them learn the self-care techniques they will need in order to manage their chronic disease, establish realistic goals for lifestyle modification, and improve adherence to their Physician prescribed treatment plan. OGB and Blue Cross Blue Shield of Louisiana are dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant. For additional information on this valuable program please contact Nurtur Health at 1-800-383-0115 and ask to speak to a *Living Well Louisiana* health coach.

C. Case Management

1. The Plan Participant may qualify for Case Management Services, at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.

2. The role of Case Management is to service the Plan Participant by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who Benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.

3. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Case Management services will not obligate the Plan to make the same or similar determination for the Plan Participant or for any other Plan Participant: The provision of Case Management services to one Plan Participant will not entitle the Plan Participant or any other Plan Participant to Case Management services or be construed as a waiver of the Claims Administrator's right to administer and enforce this Contract in accordance with its express terms.

4. Unless expressly agreed upon by the Plan, all terms and conditions of this Contract, including but not limited to maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Case Management services.

5. The Plan Participant's Case Management services will be terminated upon any of the following occurrences:

    a. The Claims Administrator determines in its sole discretion, that a Plan Participant is no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.

    b. The short and long-term goals established in the Case Management plan have been achieved, or the Plan Participant elects not to participate in the Case Management plan.

D. Alternative Benefits

1. The Plan Participant may qualify for Alternative Benefits, at the Company's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Plan Participant and to the Company.

2. The Company's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Alternative Benefits will not obligate the Company to make the same or similar determination for any other Plan Participant; nor will the provision of Alternative Benefits to a Plan Participant entitle any other Plan Participant to Alternative Benefits or be construed as a waiver of the Company's right to administer and enforce this Benefit Plan in accordance with its express terms.

3. Unless expressly agreed upon by the Company, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Alternative Benefits.

4. Alternative Benefits provided under the Article are provided in lieu of the Benefits to which the Plan Participant is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Benefit Plan.

5. The Alternative Benefits Program under this Plan does not allow a specifically excluded service to be considered for an Alternative Benefit.

6. The Plan Participant's Alternative Benefits will be terminated upon any of the following occurrences:

    a. The Claims Administrator determines, in its sole discretion, that the Plan Participant is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.

    b. The Plan Participant receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by the Claims Administrator.

ARTICLE XVI. LIMITATIONS AND EXCLUSIONS

A. Any of the limitations and exclusions listed in this Plan may be deleted or revised as shown in the Schedule of Benefits. Unless otherwise shown as covered in the Schedule of Benefits, the following are not covered, REGARDLESS OF CLAIM OF MEDICAL NECESSITY:

1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.

2. Any charges exceeding the Allowable Charge.

3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.

4. Services, Surgery, supplies, treatment, or expenses:

   a. other than those specifically listed as covered by this Benefit Plan or for which a Plan Participant has no obligation to pay, or for which no charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the State of Louisiana or any of its political subdivisions;

   b. rendered or furnished before the Plan Participant's Effective Date or after Plan Participant's coverage terminates;

   c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license;

   d. to the extent payment has been made or is available under any other contract issued by Blue Cross and Blue Shield of Louisiana or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law,

   e. paid or payable under Medicare Parts A or B when a Plan Participant has Medicare, except when Medicare Secondary Payer provisions apply;

   f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with the Claims Administrator's policies and procedures for such determinations;

   g. rendered as a result of occupational disease or injury compensable under any Workers' Compensation Law subject to the provisions of La. R.S. 23:1205(C);

   h. rendered by a Provider who is the Plan Participant's spouse, child, stepchild, parent, stepparent or grandparent.

5. Services in the following categories:

   a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;

   b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;

   c. those occurring as a result of taking part in a riot or acts of civil disobedience;

   d. those occurring as a result of a Plan Participant's commission or attempted commission of a felony; or

   e. for treatment of any Plan Participant confined in a prison, jail, or other penal institution.

6. Services, surgery, supplies, treatment, or expenses for the following REGARDLESS OF CLAIM OF MEDICAL NECESSITY:

   a. rhinoplasty;

   b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;

c. gynecomastia;

d. breast enlargement or reduction, except for Breast Reconstructive Surgical Services as specifically provided in this Benefit Plan;

e. implantation of breast implants and services;

f. implantation, removal and/or re-implantation of penile prosthesis and services;

g. diastasis recti;

h. biofeedback;

i. lifestyle/habit changing clinics and/or programs;

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

k. industrial testing or self help programs (including, but not limited to supplies and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations;

l. recreational therapy;

m. services performed primarily to enhance athletic abilities.

7. Services, Surgery, supplies, treatment, or expenses related to:

   a. eyeglasses or contact lenses, unless shown as covered as provided in this Benefit Plan;

   b. eye exercises, visual training, or orthoptics;

   c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;

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

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

   f. visual therapy.

8. Services, Surgery, supplies, treatment or expenses related to:

   a. any costs of donating an organ or tissue for transplant when a Plan Participant is a donor except as provided in this Benefit Plan;

   b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high dose chemotherapy to support transplant procedures;

   c. the transplant of any non-human organ or tissue except as approved by the Claims Administrator (porcine valve); or

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

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

   a. weight reduction programs;

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

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

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

10. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.

11. No Benefits will be provided under this Benefit Plan for any charges incurred for any Pre-Existing Condition, subject to the following:

    a. a Pre-Existing Condition exclusion is limited to a twelve (12) month period less the period of Creditable Coverage.

    b. a Pre-Existing Condition exclusion cannot be applied to pregnancy.

    c. a Pre-Existing Condition exclusion cannot be applied to eligible persons under the age of nineteen (19).

    d. a diagnosis is not necessary for a condition to be a Pre-Existing Condition.

12. Prescription drugs for which coverage is available under the Prescription Drug Benefit, unless administered during an Inpatient or Outpatient stay or those that are medically necessary requiring parenteral administration in a Physician's office.

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

14. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or and all Medically Necessary services associated with the administration of the drug. These drugs may be covered by OGB's Pharmacy Benefit Administrator. Please refer to the Schedule of Benefits or call the Pharmacy Administrator at the telephone number on the back of the Plan Participant ID card.

15. Sales tax or interest.

16. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Plan Participant's home or vehicle.

17. Charges for telephone or e-mail Consultations between a Provider and a Plan Participant, failure to keep a scheduled visit, completion of a Claim form, or to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

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

19. Elective medical or surgical abortion unless:

    a. the pregnancy would endanger the life of the mother; or

    b. the pregnancy is a result of rape or incest; or

    c. the fetus has been diagnosed with a lethal or otherwise significant abnormality.

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

21. Services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.

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

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

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

25. Services, supplies, surgery or treatment for cosmetic purposes, unless required for a Congenital Anomaly. Non-cosmetic Botox is covered, but does require Medical Review.

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

27. Diagnosis, treatment, or surgery of dentofacial anomalies including but not limited to, malocclusion, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition, except as specifically provided in this Benefit Plan.

28. Medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.

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

30. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Benefit Plan for diabetes, diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.

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

32. Nursing home care, intermediate care, custodial care, Private Duty Nursing, home observation and home health care for maintenance purposes.

33. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.

34. Immunizations required for foreign travel.

35. Counseling services such as career counseling, divorce counseling, parental counseling, job counseling, and marital/family counseling services.

36. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan.

37. Medical and Surgical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP).

38. Paternity tests and tests performed for legal purposes.

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

40. Reversal of a voluntary sterilization procedure.

41. Any Durable Medical Equipment, items and supplies over reasonable quantity limits as determined by the Plan; all defibrillators other than implantable defibrillators Authorized by the Claims Administrator.

42. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx;

43. Services or supplies for the prophylactic storage of cord blood.

44. Storage of tissue, organs, fluids or cells, with the exception of autologous bone marrow, the storage of which will be covered for a period not to exceed thirty (30) days.

45. Sleep studies, unless obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM). If a sleep study is obtained from a facility that is not accredited by one of these bodies, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.

46. Applied Behavior Analysis (ABA) that the Company has determined is not Medically Necessary. ABA rendered to Plan Participants age seventeen (17) and older. ABA rendered by a Provider that has not been certified as a behavior analyst by the Behavior Analyst Certification Board or rendered by a Provider that has not provided, to the satisfaction of Company, documented evidence of equivalent education, professional training, and supervised experience in ABA.

47. Services provided in a Residential Treatment Center for the active treatment of specific impairments of Mental Health or substance abuse, except as specifically provided in this Benefit Plan.

48. No Benefits will be provided for the following, unless otherwise determined by this Plan:

    a. immunotherapy for recurrent abortion

    b. chemonucleolysis

    c. biliary lithotripsy

    d. home uterine activity monitoring

    e. sleep therapy

    f. light treatments for seasonal affective disorder (S.A.D.)

    g. immunotherapy for food allergy

    h. prolotherapy

    i. hyperhidrosis surgery

    j. lactation therapy

    k. sensory integration therapy

ARTICLE XVII. COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits ("COB") section applies to This Plan when the Plan Participant has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.

2. If this COB section applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the Benefits of This Plan are determined before or after those of another plan. The Benefits of This Plan:

   a. will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines it's Benefits before another plan;

   b. may be reduced when under the Order of Benefit Determination Rules; another plan determines its Benefits first. That reduction is described in Section D. of this COB section, "Effect on the Benefits of This Plan."

3. When Benefits are available for Prescription Drugs, the Claims Administrator does not coordinate Benefits for Prescription Drug Claims, except for Claims that are subject to Medicare Part D and Medicare Secondary Payor requirements.

B. Definitions (Applicable only to this Article of this Benefit Plan)

1. "Plan" means any Group, Group-type, or blanket health plan that provides Benefits for services, supplies, or equipment for Hospital, surgical, medical, or dental care or treatment, including, but not limited to, coverage under:

   a. insurance policies, non-profit health service plans, health maintenance organizations, Plan Participant contracts, self-insured plans, pre-payment plans, automobile or homeowners medical payments plans, and Hospital indemnity plans with respect to Benefits under these plans in excess of three hundred dollars ($300.00) per day;

   b. government programs, including compulsory no-fault automobile insurance, unless an applicable law forbids coordinating Benefits with this type of program;

   c. labor-management trusteed plans, union welfare plans, employer organization plans, Employee Benefit organization plans, and professional association plans;

   d. any other Employee welfare Benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended;

   e. Medicare as permitted by federal law;

   f. Group-type plans or policies which can be obtained only because of employment with or membership in a particular organization, corporation, or other business entity.

   This does not include school accident insurance, individual or family Group contracts (as defined by Louisiana law), Medicaid, Hospital daily indemnity plans, specified diseases only policies, or limited occurrence policies, which provide only for intensive care or coronary care in the Hospital.

   Each plan or other arrangement for coverage is a separate plan. If an arrangement has two (2) parts and COB rules apply only to one of the two (2), each of the parts is a separate plan.

2. "This Plan" means the part of the Group's Benefit Plan and any amendments/endorsements thereto that provides Benefits for health care expenses.

3. "Primary Plan" / "Secondary Plan." The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its Benefits are determined before those of the other plan and without considering the other plan's Benefits.

When This Plan is a Secondary Plan, its Benefits are determined after those of the other plan and may be reduced because of the other plan's Benefits.

When there are more than two (2) plans covering the person, This Plan may be a Primary Plan as to one (1) or more other plans, and may be a Secondary Plan as to a different plan or plans.

4. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one (1) or more plans covering the person for whom the Claim is made.

   When a plan provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a Benefit paid.

   When Benefits are reduced under a Primary Plan because a Covered Person does not comply with the Primary Plan's provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Authorization of admissions or services, and preferred Provider arrangements.

5. "Claim Determination Period" means that part of the Plan Year during which a person covered by This Plan is eligible to receive Benefits under the provisions of This Plan.

C. Order of Benefit Determination Rules

1. When there is a basis for a Claim under This Plan and another plan, This Plan is a Secondary Plan, which has its Benefits determined after those of the other plan, unless:

   a. the other plan has rules coordinating its Benefits with those of This Plan; and

   b. both those rules and This Plan's rules, in paragraph 2. below, require that This Plan's Benefits be determined before those of the other plan.

2. This Plan determines its order of Benefits using the first of the following rules, which applies:

   a. Non-Dependent/Dependent: The Benefits of the plan which covers the person as an Employee, Plan Participant (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

      (1) Secondary to the plan covering the person as a Dependent; and

      (2) Primary to the plan covering the person as other than a Dependent (e.g., a retired Employee); then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.

   b. Dependent Child/Parents Not Separated or Divorced: Except as stated in paragraph 2(c) below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents":

      (1) the Benefits of the plan of the parent whose birthday falls earlier in the Plan Year are determined before those of the plan of the parent whose birthday falls later in the Plan Year; but

      (2) if both parents have the same birthday, the Benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

      However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of Benefits, the rule in the other plan will determine the order of Benefits.

c. Dependent Child/Separated or Divorced Parents: If two (2) or more plans cover a person who is a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:

(1) first, the plan of the parent with custody of the child;

(2) then, the plan of the spouse of the parent with custody of the child; and

(3) finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the plan of that parent has actual knowledge of those terms, the Benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply when any Benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint Custody: If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of Benefit determination rules outlined in Section C(2)(b).

e. Active/Inactive Employee: The Benefits of a plan which covers a person as an Employee who is not terminated, laid off, or retired (or as that Employee's Dependent) are determined before those of a plan which covers that person as a terminated, laid off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

f. Continuation Coverage: If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of Benefit determination:

(1) first, the Benefits of a plan covering the person as an Employee or Plan Participant or (or as that person's Dependent);

(2) second, the Benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

g. Longer/Shorter Length of Coverage: If none of the above rules determines the order of Benefits, the Benefits of the plan, which covered an Employee or Plan Participant longer, are determined before those of the plan, which covered that person for the shorter time.

D. Effects on the Benefits of this Plan

1. This Section applies when, in accordance with Section C., "Order of Benefit Determination Rules," this Plan is a Secondary Plan as to one or more other plans. In that event the Benefits of This Plan may be reduced, as described in this section. Such other plan or plans are referred to as "the other plans" in Paragraph 2. immediately below.

2. Reduction in This Plan's Benefits

The Benefits of This Plan will be reduced when the sum of:

a. the Benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB section; and

b. the Benefits that would be payable for the Allowable Expenses under the other plans in the absence of provisions with a purpose like that of this COB section, whether or not Claims are made, would be more than those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of

This Plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of This Plan.

E. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts the Claims Administrator needs. The Claims Administrator may get needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give the Claims Administrator any facts needed to pay the Claim.

F. Facility of Payment

A payment made under another plan may include an amount, which should have been paid under This Plan. The Claims Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. To the extent, such payments are made; they discharge the Plan from further liability. The term "payment made" includes providing Benefits in the form of services, in which case the payment made will be deemed the reasonable cash value of any Benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments that the Claims Administrator made is more than it should have paid under this COB section, the Claims Administrator may recover the excess. The Claims Administrator may get such recovery or payment from one or more of:

1. the persons the Claims Administrator has paid or for whom the Claims Administrator has paid;

2. insurance companies;

3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

If the excess amount is not received when requested, any Benefits due under This Plan will be reduced by the amount to be recovered until such amount has been satisfied.

ARTICLE XVIII. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP AND ALL PLAN PARTICIPANTS.

THE GROUP ENTERS INTO THIS PLAN ON BEHALF OF THE ELIGIBLE INDIVIDUALS ENROLLING UNDER THIS PLAN. ACCEPTANCE OF THIS PLAN BY THE GROUP IS ACCEPTANCE BY AND BINDING UPON:

A. This Benefit Plan

1. This Benefit Plan, including the Application for Group Coverage, and any Application Benefit Change Forms, expressing the entire money and other consideration therefore, Schedule of Benefits, and any attached amendments or endorsements, constitutes the entire contract between the parties.

2. 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. To the extent that 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.

3. 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 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 the Plan Participant's care or treatment.

4. The Plan Administrator, OGB shall administer the Plan in accordance with its terms and establishes its 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

5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, health care providers, or other third parties relative to this 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 its subsidiaries, affiliates, subcontractors, or designees.

B. Amending and Terminating the Plan

The Employer intends to maintain this Plan indefinitely; however, it reserves its right, at any time, to amend, suspend or terminate the plan in whole or in part. This includes amending the Benefits under the Plan or the trust agreement, if any. No change or waiver of any Benefit Plan provision will be effective until approved by OGB's chief executive officer or his delegate.

C. Identification Cards and Benefit Plan

The Claims Administrator will prepare an ID card for each Covered Employee. The Claims Administrator will issue a Benefit Plan to the Group and deliver the Covered Employees materials directly to each Employee. The Plan Participant's copy of the Benefit Plan shall serve as his certificate of coverage.

D. Benefits which Plan Participants Are Entitled

1. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Plan and regularly included in such Provider's charges.

2. The Claims Administrator, in its sole discretion, may set a minimum dollar amount for Claims to be reviewed for possible Pre-Existing Conditions.

E. Termination of a Plan Participant's Coverage

1. The Plan may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this policy. 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 there from, as to any proposed covered Plan Participant shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective date of coverage or terminated within three (3) years of the Plan Participant's Effective Date, for fraud or intentional misrepresentation of material fact. Company will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section.

2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, a Plan Participant's coverage terminates as provided below:

   a. the Employee's coverage and that of all his Dependents terminates on the last day of the month following the date of termination;

   b. the coverage of the Employee's spouse will terminate on the last day of the month following a final decree of divorce or other legal termination of marriage;

   c. the coverage of a Dependent will terminate on the last day of the month following the date the Dependent ceases to be an eligible Dependent;

   d. upon the death of an Employee, the coverage of all of his surviving Dependents will terminate on the last day of the month following the date that the death occurred. However, a surviving spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.

3. In the event the Group cancels this Plan or the Claims Administrator terminates this Plan for nonpayment of the appropriate payment when due or because the Group fails to perform any obligation required by this Plan, such cancellation or termination alone will operate to end all rights of the Plan Participant to Benefits under this Plan as of the Effective Date of such cancellation or termination. The Group shall have the obligation to notify its Plan Participants, participants, and beneficiaries of such cancellation or termination. The Claims Administrator shall have no such obligation of notification at the Plan Participant level.

4. In the event of the occurrence of the provisions of paragraphs a., b., c. or d. above, if the Plan Participant is an Inpatient in a Hospital on the date coverage ends, medical Benefits in connection with the Admission for that patient will end on the date coverage ends. No Benefits are available to a Plan Participant for Covered Services rendered after the date of termination of a Plan Participant's coverage.

5. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Plan Participant for Covered Services rendered after the date of cancellation or termination of a Plan Participant's coverage.

6. The Group reserves the right to automatically change the Employee's class of coverage to reflect when no more children or grandchildren are covered under this Benefit Plan.

7. When the Group's coverage ends because the plan ceases to exist or COBRA is exhausted, the Louisiana Health Plan (LHP) can be contacted regarding possible health coverage for eligible individuals. For detailed information regarding price and available Benefits, Plan Participants may write to LHP at P.O. Drawer 83880, Baton Rouge, LA 70884-3880 or may call LHP at (225) 926-6245 or (800) 736-0947. Timeliness of communication with LHP is important.

F. Filing Claims

1. A Claim is a written or electronic proof of charges for Covered Services that a Plan Participant has incurred during the time-period the Plan Participant was insured under this Plan. The Claims Administrator encourages Providers to file claims, in a form acceptable to the Claims Administrator, within ninety (90) days from the date services are rendered, but no later than twelve (12) months after the date of service. Benefits will be denied for Claims filed any later than twelve (12) months from the date of service. Benefit Plan provisions in effect at the time the service or treatment is received shall govern the processing of any Claim filed or expense actually incurred as a result of the service or treatment rendered.

2. Most Plan Participants with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Plan Participant. However, if the Plan Participant must file a claim to access their Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. The Prescription Drug Claim Form may require the signature of the dispensing pharmacist. The claim form should then be sent to OGB's Pharmacy Benefit Manager, whose telephone number should be found on the Plan Participant's ID card.

G. Legal Action

No lawsuit may be filed:

1. any earlier than the first sixty (60) days after notice of Claim has been given; or

2. any later than twelve (12) months after the date services are rendered.

H. Release of Information

The Claims Administrator may request that the Plan Participant or the Provider furnish certain information relating to the Plan Participant's claim for Benefits. The Claims Administrator will hold such information, records, or copies of records as confidential except where in the Claims Administrator's discretion the same should be disclosed.

I. Assignment

1. The Plan Participant's rights and Benefits payable under this Plan are personal to the Plan Participant and may not be assigned in whole or in part by the Plan Participant. The Claims Administrator will recognize assignments of Benefits to Hospitals if both this Plan and the Provider are subject to La. R.S. 40:2010. If both this Plan and the Provider are not subject to La. R.S. 40:2010, the Claims Administrator will not recognize assignments or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the Plan or the Claims Administrator liable to any third party to whom the Plan Participant may be liable for the cost of medical care, treatment, or services.

2. The Plan reserves the right to pay Preferred Care Network Providers, and/or Providers in the Blue Cross and Blue Shield of Louisiana Participating Provider Network directly instead of paying the Plan Participant.

J. Plan Participant/Provider Relationship

1. The choice of a Provider is solely the Plan Participants.

2. The Claims Administrator and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or Employees of each other for any purpose whatsoever. The Claims Administrator does not render Covered Services but only makes payment for Covered Services that the Plan Participant receives. The Claims Administrator is not liable for any act or omission of any Provider, or for any Claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any Network Provider or in any Network Provider's facilities. The Claims Administrator has no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.

3. The use or non-use of an adjective such as Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

K. Applicable Law

This Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law. This Plan is not subject to regulation by any state other than the State of Louisiana. If any provision of this Benefit Plan is in conflict with any applicable statutes or regulations of the U.S. or the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute or regulation.

L. This Benefit Plan and Medicare

When an individual is covered by this Plan and by Medicare, Medicare laws and regulations govern the order of Benefit, that is, whether Medicare is the primary or secondary payer.

1. Except as provided in Subsection C (below), when an individual is covered by this Plan and by Medicare, and:

   a. this Plan is the primary payer, Benefits will be paid without regard to Medicare coverage;

   b. Medicare is the primary payer; Eligible Expenses under this Plan will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. All provisions of this Plan, including all provisions related to Deductibles, Coinsurance, limitations and exclusions will be applied.

2. The following applies to Retirees and to covered spouses of Retirees who attain or have attained the age of sixty-five (65) on or after July 1, 2005:

   a. upon attainment of age sixty-five (65), a Retiree and/or the Retiree's spouse may be eligible for Medicare if the Retiree or Retiree's spouse has sufficient earnings credits;

   b. a Retiree or spouse of a Retiree who attains or has attained age sixty-five (65), when either has sufficient earnings credits to be eligible for Medicare, MUST ENROLL in Medicare Part A AND Medicare Part B in order to receive Benefits under this Plan except as specifically provided in paragraph 3, below;

   c. if such Retiree or spouse of a Retiree is not enrolled in Medicare Part A and Medicare Part B, NO BENEFITS will be paid or payable under this Plan except Benefits payable as secondary to the Part of Medicare in which the individual is enrolled;

   d. a Retiree and spouse of a Retiree who do not have sufficient earnings credits to be eligible for Medicare must provide written verification from the Social Security Administration or its successor.

M. Notices

Any notice required under this Benefit Plan must be in writing. Notice given to the Claims Administrator will be sent to the address stated in this Benefit Plan. Any notice required to be given will be considered delivered when deposited in the United States mail, postage prepaid, addressed to the Plan Participant at his address as the same appears on the Claim's Administrator's records, or to the Group at the address as the same appears in this Benefit Plan. The Claims Administrator, the Group, or the Plan Participant may, by written notice, indicate a new address for giving notice.

N. Job-Related Injury or Illness

The Group must report to the appropriate governmental agency any job-related injury or illness of a Employee where so required under the provisions of any legislation of any governmental unit. This Benefit Plan excludes Benefits for any services covered in whole or in part by Workers' Compensation laws and/or rendered as a result of occupational disease or injury, subject to the provisions of L.R.S. 23:1205(C). In the event that the Claims Administrator initially extends Benefits and a compensation carrier or employer makes any type of settlement with the Plan Participant, with any person entitled to receive settlement when the Plan Participant dies, or if his injury or illness is found to be compensable under law, the Group or the Plan Participant must reimburse the Plan for Benefits extended or direct the compensation carrier to make such reimbursement. The Claims Administrator will be entitled to such reimbursement even if the settlement does not mention or excludes payment for health care expenses.

O. Subrogation and Reimbursement

Upon payment of any eligible Benefits covered under this Plan, the Office of Group Benefits shall succeed and be subrogated to all rights of recovery of the covered Employee, his Dependents or other Covered Persons, or their heirs or assigns, for whose benefit payment is made, and they shall execute and deliver instruments and papers and do whatever is necessary to secure such rights, and shall do nothing after loss to prejudice such rights.

The Office of Group Benefits has an automatic lien against and shall be entitled, to the extent of any payment made to a covered Employee, his Dependents or other Covered Persons, to 100% of the proceeds of any

settlement or judgment that may result from the exercise of any rights of recovery of a covered Employee, his Dependents or other Covered Persons, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made.

To this end, covered Employees, their Dependents, or other Covered Persons agree to immediately notify the Office of Group Benefits 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 when a Covered Person recovers under, BUT NOT LIMITED TO, 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 to first recovery to the extent of any judgment, settlement, or any payment made to the covered Employee, his Dependents or other Covered Persons. These rights apply regardless of whether such recovery is designated as payment for, but not limited to, pain and suffering, medical benefits, or other specified damages, even if he is not made whole (i.e., fully compensated for his injuries).

P. Right of Recovery

Whenever any payment for Covered Services has been made by the Plan in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or whenever payment has been made in error by the Claims Administrator for non-covered services, the Claims Administrator will have the right to recover such payment from the Plan Participant or, if applicable, the Provider. As an alternative, the Claims Administrator reserves the right to deduct from any pending Claim for payment under this Plan any amounts that the Claims Administrator is owed by the Plan Participant or the Provider.

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

R. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between the Claims Administrator and the Group, that the Claims Administrator 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 the Plan to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that the Claims Administrator 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 agreement based upon representations by any person other than the Claims Administrator and that no person, entity, or organization other than the Claims Administrator shall be held accountable or liable to the Plan Administrator for any obligations to the Plan created under this agreement. This paragraph shall not create any additional obligations whatsoever on the Claims Administrator's part other than those obligations created under other provisions of this claims administration agreement.

S. Out-of-Area Services

The Claims Administrator has a variety of relationships with other Blue Licensees referred to generally as "Inter-Plan Programs." Whenever Plan Participants obtain healthcare services outside of Blue Cross and Blue Shield of Louisiana's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

Typically, when accessing care outside Blue Cross and Blue Shield of Louisiana's service area, Plan Participants will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Plan Participants may obtain care from non-participating healthcare providers. Claims Administrator's payment practices in both instances are described below.

1. BlueCard® Program

   Under the BlueCard® Program, when Plan Participants access covered healthcare services within the geographic area served by a Host Blue, the 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 participating healthcare Providers.

   Whenever Plan Participants access covered healthcare services outside Blue Cross and Blue Shield of Louisiana's service area and the claim is processed through the BlueCard® Program, the amount Plan Participants pay for covered healthcare services from Participating Providers 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 Claims Administrator.

   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 the 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, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Claims Administrator uses for Plan Participant's claim because they will not be applied retroactively to claims already paid.

   Laws in a small number of states may require the Host Blue to add a surcharge to a calculation. If any state laws mandate other liability calculation methods, including a surcharge, Claims Administrator would then calculate your liability for any covered healthcare services according to applicable law.

2. Medicare Supplemental/Medigap/Medicare Complementary

   Under Medigap/Medicare Supplemental/Medicare Complementary plans, when a Plan Participant receives treatment from a healthcare provider that participates with the Host Blue and accepts Medicare assignment, the amount the Plan Participant pays for services otherwise covered by the federal Medicare Program will be calculated based on the Medicare allowable amount. If the healthcare provider does not accept Medicare assignment, Plan Participant may be liable for the difference between the amount that the provider bills and the Medicare limiting charge, which will include the payment Claims Administrator will make for the covered services as set forth in Group's agreement.

   If Plan Participant has additional benefits for healthcare services which Medicare would not otherwise cover, the amount Plan Participant pays for such services when received from a participating healthcare provider will be calculated based on the lower of either billed covered charges or negotiated price made available to Claims Administrator by the Host Blue.

3. Non-Participating Healthcare Providers outside Blue Cross and Blue Shield of Louisiana's Service Area

When covered healthcare services are provided outside of Blue Cross and Blue Shield of Louisiana's service area by non-participating healthcare providers, the amount Plan Participant pays for such services is described below.

a. Plan Participant Liability Calculation

When covered healthcare services are provided outside of Claims Administrator's service area by non-participating healthcare providers, the amounts a Plan Participant pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Plan Participant may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph.

b. Exceptions

In some exception cases, Claims Administrator may pay claims from non-participating healthcare providers outside of Blue Cross and Blue Shield of Louisiana's service area based on the provider's billed charge, the payment Claims Administrator would make if it were paying a non-participating provider inside of its service area (where the Host Blue's corresponding payment would be more than the Plan's in-service area Non-Participating Provider payment), or in Claims Administrator's sole and absolute discretion, it may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Plan Participant may be responsible for the difference between the amount that the Non-Participating healthcare provider bills and payment the Claims Administrator will make for the covered services as set forth in this paragraph.

c. Medigap/Medicare Supplemental/Medicare Complementary Plans

Under Medigap/Medicare Supplemental/Medicare Complementary plans, when Plan Participant receives treatment from a healthcare provider that does not participate with the Host Blue, but does accept Medicare assignment, the amount Plan Participant pays for services otherwise covered by the federal Medicare Program will be calculated based on the Medicare allowable amount. If the healthcare provider does not accept Medicare assignment, Plan Participant may be liable for the difference between the amount that the provider bills and the Medicare limiting charge, which will include the payment Claims Administrator will make for the covered services as set forth in this paragraph. If Plan Participant has additional benefits for healthcare services which Medicare would not otherwise cover, the amount Plan Participant pays for such services provided by a healthcare provider not participating with the Host Blue will be calculated based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, Plan Participant may be liable for the difference between the amount that the Non-Participating healthcare provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph.

T. Compliance with HIPAA Privacy Standards

Certain Plan Participants of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees 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 Employees are permitted to have such access subject to the following:

1. General

The Plan shall not disclose Protected Health Information to any Plan Participant of the Employer'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 or condition of an individual, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

   Protected Health Information disclosed to Plan Participants of the Employer'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 health care operations. The terms "payment" and "health care 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 health care. "Health Care Operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care 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 Employees

   The Plan shall disclose Protected Health Information on to Plan Participants of the Employer'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, "Plan Participants of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employers.

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

   b. Use and Disclosure Restricted. An authorized Plan Participant of the Employer'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 Plan Participant of the Employer'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) investigation of 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) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Employer

   The Employer must provide certification to the Plan that it 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 Employer with respect to such information;

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

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

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

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

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

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

i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains 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 Plan Participant of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

The following Plan Participants of the Office of Group Benefit's workforce are designated as authorized to receive Protected Health Information from OFFICE OF GROUP BENEFITS HEALTH PLAN ("the Plan") in order to perform their duties with respect to the Plan:

- OGB Customer Service management and representatives
- OGB Agency Services management and representatives
- OGB Eligibility Services management and representatives
- OGB Executive Staff
- OGB Contract Manager and Reviewer
- OGB IT Supervisors
- OGB Legal Services management and representatives
- OGB Medical Director and Nursing Staff
- OGB Provider Relations supervisors

U. Compliance with HIPAA Electronic Security Standards

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

1. The Employer 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 Employer 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 Employer 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 Employer 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 Employees and (4) Certification of Employers described above in this Article.

ARTICLE XIX. OGB COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

THE PLAN WANTS TO KNOW WHEN A PLAN PARTICIPANT IS UNHAPPY ABOUT THE CARE OR SERVICES THEY RECEIVE FROM THE CLAIMS ADMINISTRATOR, OR ONE OF THE CLAIMS ADMINISTRATOR'S PROVIDERS. IF A PLAN PARTICIPANT WANTS TO REGISTER A COMPLAINT OR FILE A FORMAL WRITTEN GRIEVANCE ABOUT THE CLAIMS ADMINISTRATOR OR A PROVIDER, THEY SHOULD REFER TO THE PROCEDURES BELOW.

A Plan Participant may be unhappy about decisions the Claims Administrator makes on behalf of the Group, regarding covered services. The Plan considers a Plan Participant's request to change the coverage decision as an Appeal. The Plan defines an Appeal as a request from a Plan Participant or authorized representative to change a previous decision made by the Claims Administrator about covered services. Examples of issues that qualify as appeals include denied Authorizations, claims based on adverse determinations of Medical Necessity, or benefit determinations.

The Plan Participant's appeal rights are outlined below, after the Complaint and Grievance procedure. In addition to the Appeals rights, the Plan Participant's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of the Claim Administrator's coverage decisions when they concern medical necessity determinations. The Plan Participant may have the right to review their file and present evidence or testimony as part of the final internal review process. There is an expedited Appeals process for urgent care claims where standard time frames would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function.

Complaint and Grievance Procedure

A Complaint is an oral expression of dissatisfaction with the Claims Administrator or with Provider services. A quality of care concern addresses the appropriateness of care given to a Plan Participant. A quality of service concern addresses the Claim Administrator's services, access, availability or attitude and those of the network Providers.

To register a Complaint

Call the Plan's customer service department at 1-800-392-4089. The Claims Administrator will attempt to resolve a Plan Participant's Complaint at the time of their call.

To file a formal Grievance

A Grievance is a written expression of dissatisfaction with the Claims Administrator or with Provider services. If a Plan Participant does not feel their Complaint was adequately resolved or the Plan Participant wishes to file a formal Grievance, the Plan Participant must submit this in writing. The Plan's customer service department will assist the Plan Participant if necessary. Send written Grievances to:

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

A response will be mailed to the Plan Participant within thirty (30) business days after the Claims Administrator receives the Plan Participant's written Grievance. If the Plan Participant is not happy with the handling of their Grievance, the Plan Participant has the right to elevate their Grievance to the second and final level. The Plan must receive the Plan Participant's request for a second level Grievance no later than sixty (60) calendar days from the date the Claims Administrator notifies the Plan Participant of the answer to the first level Grievance. Grievances received after this date will not be considered. A separate panel reviews each level of Grievance.

Informal Reconsideration

An Informal Reconsideration is a Provider's telephone request to speak to the Plan's Medical Director or a peer reviewer on the Plan Participant's behalf about a Utilization Management decision that the Claims Administrator has made. An Informal Reconsideration is typically based on submission of additional information or a Physician-to-Physician discussion. An Informal Reconsideration is available only for initial determinations that are requested within ten (10) days of the denial or Concurrent Review determinations. The Claims Administrator will conduct an Informal Reconsideration within one (1) working day of the receipt of the request.

Appeal Procedures

Multiple requests to appeal the same claim, service, issue or date of service will not be considered at any level of review.

Appeal Process

The Claims Administrator will distinguish the Plan Participant's Appeal as an administrative Appeal, a Medical Necessity Appeal or an Investigational Appeal. The procedure has two (2) levels of appeal, the first by the Claims Administrator or its designee, and the second by the Plan Administrator, OFFICE OF GROUP BENEFITS (OGB). Plan Participants are encouraged to submit written comments, documents, records, and other information relating to the Claim for Benefits. 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 covered person's Claim for Benefits.

The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in their Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in an internal review of a denial. The authorized representative may be the Plan Participant's treating Provider.

Persons not involved in previous decisions regarding the Plan Participant's claim will decide all Appeals. A Physician or other health care professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the Plan Participant's Claim will review Medical Necessity Appeals.

First Level Appeal

If the Plan Participant is not satisfied with the denial of services, the Plan Participant, his authorized representative, or a Provider acting on behalf of the Plan Participant, must submit the initial written request to appeal within one hundred eighty (180) days following Plan Participant's receipt of an initial adverse Benefit determination. The Plan Participant may submit appeals or communicate with the Claims Administrator regarding any Appeal by writing to:

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

If You have questions or need assistance putting the Appeal in writing, You may call the Plan's customer service department at 1-800-392-4089. Requests submitted to the Plan after one - hundred eighty (180) days of the denial will not be considered.

If the initial denial is overturned on the Plan Participant's administrative, Medical Necessity or Investigational appeal, the Claims Administrator will process the Plan Participant's Claim and will notify the Plan Participant and all appropriate Providers, in writing, of the first level Appeal decision. If the Claims Administrator's initial denial is upheld, the Plan Participant will be notified and all appropriate Providers when applicable, in writing, of the Claim's Administrator's decision. The decision will be mailed within thirty (30) working days of the Plan Participant's request, unless the Plan Participant, his authorized representative and the Claims Administrator mutually agrees that an extension of the time is warranted.

Second Level Appeal

Within sixty (60) calendar days of the date of the first level Appeal decision, a Plan Participant who is not satisfied with the decision may initiate a voluntary second level of Appeal. Requests submitted after sixty (60) days of the denial will not be considered. These requests should be made to the OFFICE OF GROUP BENEFITS HEALTH PLAN within sixty (60) calendar days of the denial of the First Level Appeal at the following:

Attention: Administrative Claims Review
Office of Group Benefits
Post Office Box 44036
Baton Rouge, Louisiana 70804

Requests submitted to the Claims Administrator will be forwarded to the OFFICE OF GROUP BENEFITS.

Medical Necessity Appeals

If the Plan Participant is not satisfied with the denial of services, the Plan Participant, their authorized representative, including a Provider acting on their behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Plan Participant's receipt of an initial adverse Benefit determination. 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

Requests submitted to the Claims Administrator after one hundred eighty (180) days of the denial will not be considered.

If the initial denial is overturned on the Plan Participant's Investigational Appeal, the Claims Administrator will process the Claim and will notify the Participant and all appropriate Providers, in writing, of the internal Appeal decision. If the initial denial is upheld, the Claims Administrator will notify the Plan Participant and all appropriate Providers, in writing, of the decision and advise the Plan Participant of their right to request an external Appeal. The decision will be mailed within thirty (30) days of the Plan Participant's request, unless the Participant, their authorized representative and the Claims Administrator mutually agree that an extension of the time is warranted. At that time, the Claims Administrator will inform the Plan Participant of their right to begin the external Appeal process if the Claim meets the criteria.

Investigational Denials

If the Plan Participant is not satisfied with the denial of services, the Plan Participant, their authorized representative, including a Provider acting on their behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Plan Participant's receipt of an initial adverse Benefit determination. 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

Requests submitted to the Claims Administrator after one hundred eighty (180) days of the denial will not be considered.

If the initial denial is overturned on the Plan Participant's Investigational Appeal, the Claims Administrator will process the Claim and will notify the Plan Participant and all appropriate Providers, in writing, of the internal Appeal decision. If the initial denial is upheld, the Claims Administrator will notify the Plan Participant and all appropriate Providers, in writing, of the decision and advise the Plan Participant of their right to request an external Appeal. The decision will be mailed within thirty (30) days of the Plan Participant's request, unless the Plan Participant, their authorized representative and the Claims Administrator mutually agree that an extension of the time is warranted.

At that time, the Claims Administrator will inform the Plan Participant of their right to begin the external Appeal process if the Claim meets the criteria.

- An Investigational denial is one which is based on: (1) if the item or service is subject to FDA approval, it must be so approved; and, (2) if the item is not subject to FDA approval, use of the item or service must be supported by medical or scientific evidence.

Expedited Internal Appeal

The Plan provides an Expedited Internal Appeal process for review of an adverse determination involving a situation where the time frame of the standard Appeal would seriously jeopardize the Plan Participant's life, health or ability to regain maximum function. In these cases, the Claims Administrator will make a decision no later than seventy-two (72) hours after the review commences.

An Expedited Appeal is a request concerning an Admission, availability of care, continued stay, or health care service for a covered person who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility. Expedited Appeals are not provided for review of services previously rendered. An Expedited Appeal shall be made available to, and may be initiated by, the covered person or an authorized representative, with the consent of the covered person's treating health care Provider, or the Provider acting on behalf of the covered person. Requests for an Expedited Internal Appeal may be oral or written and should be made to:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045
1-800-392-4089

Independent External Review

If the Plan Participant still disagrees with the Appeal denial and have the concurrence of his treating Physician (Medical Necessity/Investigational denials), he may request an independent external Appeal conducted by a non-affiliated Independent Review Organization (IRO). Within one-hundred twenty (120) days of receipt of the first level appeal decision, the Plan Participant should send his written request for an External Review to:

Attention: Administrative Claims Review
Office of Group Benefits
Post Office Box 44036
Baton Rouge, Louisiana 70804

Requests submitted after one hundred twenty (120) days of receipt of the denial will not be considered.

The IRO decision will be considered a final and binding decision on both the Plan Participant and the Claims Administrator. The IRO review will be completed within forty-five (45) days after the Appeal is commenced if the parties agree to a longer period. The IRO will notify the Plan Participant or his authorized representative and health care Provider of its decision.

Expedited External Review

An Expedited External Review is a request for immediate review, by an Independent Review Organization (IRO), of an adverse initial determination not to Authorize continued services for Plan Participants currently in the emergency room, under observation in a facility or receiving Inpatient care. Your health care Provider must request the Expedited External Review. Expedited External Reviews are not provided for review of services previously rendered. An Expedited External Review of an adverse decision is available if pursuing the standard Appeal procedure could seriously jeopardize the Plan Participant's life, health or ability to regain maximum function.

The Claims Administrator will forward all pertinent information to the IRO so the review is completed no later than seventy-two (72) hours after the review commences.

Binding Nature of External Review of a Medical Necessity/Investigational Decision

The process of seeking a Medical Necessity/Investigational Appeal is set forth above. All external review decisions are binding on the Claims Administrator and the covered person for purposes of determining coverage under a health benefit plan that requires a determination of Medical Necessity for a medical service to be covered. This Appeals process shall constitute the Plan Participant's sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary.

OGB Administrative Claims Review Procedure and Decisions

Review shall be based upon a documentary record which includes:

- all information in the possession of the program relevant to the issue presented for review;
- all information submitted by the covered person in connection with the request for review; and
- any and all other information obtained by the committee in the course of its review.

Upon completion of the review OGB will render its decision which will be based on this plan of benefits and the information included in the record. The decision will contain a statement of reasons for the decision. A copy of the decision will be mailed to the covered person and any representative thereof.

Right to Require Medical Examinations

The Plan has the right to require that a medical examination be performed on any claimant for whom a claim is pending as often as may be reasonably required. If the Plan requires a medical examination, it will be performed at the Plan's expense. The Plan also has a right to request an autopsy in the case of death, if allowed by state law.

Exhaustion

Upon completion of the appeals process under this section, a claimant will have exhausted his administrative remedies under the Plan. If the Plan Manager fails to complete a claim determination or Appeal within the time limits set forth above, the claimant may treat the claim or Appeal as having been denied, and the claimant may proceed to the next level in the review process. After exhaustion, a claimant may pursue any other legal remedies available to him. Additional information may be available from a local U.S. Department of Labor Office.

Legal Actions and Limitations

No action at law or inequity may be brought with respect to Plan benefits until all remedies under the Plan have been exhausted and then prior to the expiration of the applicable limitations period under applicable law.

ARTICLE XX. HOW TO OBTAIN CARE WHILE TRAVELING, MAKE POLICY CHANGES AND FILE CLAIMS

A. How to Obtain Care Using BlueCard® While Traveling

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

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

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

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

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

e. The Plan Participant must obtain any required Authorizations from Blue Cross and Blue Shield of Louisiana.

B. How to File Insurance Claims

1. The Claims Administrator and most Providers have entered into agreements that eliminate the need for a Plan Participant to personally file a claim for Benefits. Preferred or Participating Providers will file Claims for Plan Participants either by mail or electronically. In certain situations, the Provider may request the Plan Participant to file the claim. If the Plan Participant's Provider does request them to file directly with the Claims Administrator the following information will help the Plan Participant in correctly completing the claim form. If the Plan Participant needs to file a paper claim, send it to:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

The Plan Participant's Blue Cross and Blue Shield ID card shows the way the name of the Plan Participant of the Group appears on the Claims Administrator's records. (If the Plan Participant has Dependent coverage the name(s) are recorded as shown in the enrollment information the Claims Administrator received.) The ID card also lists the Plan Participant's Benefit Plan number (ID #). This number is the identification to the Plan Participant's membership records and should be provided to the Claims Administrator each time a claim is filed. To assist in promptly handling the Plan Participant's Claims, please be sure that:

a. an appropriate claim form is used;

b. the Benefit Plan number (ID #) shown on the form is identical to the number on the ID card;

c. the patient's date of birth is listed;

d. the patient's relationship to the Employee is correctly stated;

e. all charges are itemized, whether on the claim form or on the attached statement;

f. the date of service (date of Admission to a Hospital or other Provider) or date of treatment is correct;

g. the Provider includes a diagnosis code and a procedure code for each service/treatment rendered;

h. the claim is completed and signed by the Plan Participant and the Provider.

NOTE: Be sure to check all Claims for accuracy. The Benefit Plan number (ID #) must be correct. It is important that the Plan Participant keep a copy of all bills and Claims submitted.

C. Additional Information for Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

When the Plan Participant or an enrolled Plan Participant of the Plan Participant's family is being admitted to a Preferred or Participating Provider, the Plan Participant should show their Blue Cross and Blue Shield ID card to the admitting clerk. The Provider will file the claim with the Claims Administrator. The Plan's payments will go directly to the Preferred and Participating Provider. The Provider will then bill the Plan Participant directly for any remaining balance. The Plan Participant will receive an Explanation of Benefits after the claim has been processed.

2. Emergency Room or Outpatient Department Claims

   The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility. However, in some instances involving Emergencies or Outpatient treatment the Provider may ask for payment directly from the Plan Participant. If this occurs, the Plan Participant should obtain an itemized copy of the bill, be sure the claim form correctly notes the Benefit Plan number (ID #), the patient's date of birth, as well as the patient's relationship to the Employee. The Provider must mark the statement or claim form PAID. The Plan Participant should forward this statement to Blue Cross and Blue Shield of Louisiana.

3. Mental Health and Substance Abuse Claims

   For help with filing a Claim for Mental Health or substance abuse, the Plan Participant should contact OGB's Mental Health and substance abuse benefits administrator.

4. Other Medical Claims

   When the Plan Participant receives other medical services (clinics, Provider offices, etc.) the Plan Participant should ask if the Provider is a Preferred or Participating Provider. If yes, this Provider will file the Plan Participant's claim with the Claims Administrator. In some situations, the Providers may request payment and ask the Plan Participant to file. If this occurs, the Plan Participant should be sure the claim form is complete before forwarding to Blue Cross and Blue Shield of Louisiana.

   If the Plan Participant is filing the claim, the claim must contain the itemized charges for each procedure or service. NOTE: Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills. Itemized bills submitted with claim forms must include the following:

   a. full name of patient

   b. date(s) of service

   c. description of and procedure code for service

   d. diagnosis code

   e. charge for service

   f. name and address of Provider of service.

5. Nursing Services Claims

   A receipt must be obtained for nursing services from each nurse indicating the name of the patient and the number of days covered by each receipt. Each receipt must also be signed by the nurse with the initials RN or LPN and registry number. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary must be filed with the receipts for nursing services.

6. Durable Medical Equipment (DME) Claims

   Charges for rental or purchase of wheelchairs, braces, crutches, etc. must be on the bill of the supplying firm, giving a description of the item rented or purchased, the date, the charge, and the patient's name. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary must also be filed with these bills.

7. If the Plan Participant Has a Question about a Claim

   If the Plan Participant has a question about the processing or payment of a claim, the Plan Participant can write to the Claims Administrator at the address below or the Plan Participant may call the Plan's customer service department at the number shown on his ID card or any of the Claims Administrator's local service offices.* If the Plan Participant calls for information about a claim, the Claims Administrator can help the Plan Participant better if they have pertinent information at hand, particularly the Benefit Plan number, patient's name and date of service.

   Blue Cross and Blue Shield of Louisiana
   5525 Reitz Avenue
   P.O. Box 98027
   Baton Rouge, LA 70898-9917

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

* Blue Cross and Blue Shield of Louisiana has local service offices located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Monroe and Shreveport.

ARTICLE XXI. RESPONSIBILITIES OF PLAN ADMINISTRATION

A. Plan Administrator

The Office of Group Benefits HMO Plan for State of Louisiana Employees And Retirees Medical Benefit Plan is the Benefit Plan of OGB, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by OGB to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, OGB shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Benefit Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Benefit Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Benefit Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section.

Service of legal process may be made upon the Plan Administrator.

B. Duties of the Plan Administrator

1. to administer the Plan in accordance with its terms;

2. to interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;

3. to decide disputes that may arise relative to a plan participant's rights;

4. to keep and maintain the Plan documents and all other records pertaining to the Plan;

5. to appoint a Claims Administrator to pay Claims; and

6. to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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.

1. Fiduciary Duties

A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to the employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

a. 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;

b. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

D. The Claims Administrator is not a Fiduciary

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

GENERAL PLAN INFORMATION

NAME OF PLAN:	OFFICE OF GROUP BENEFITS HMO PLAN for STATE of LOUISIANA EMPLOYEES and RETIREES
NAME AND ADDRESS OF EMPLOYER/PLAN SPONSOR:	OFFICE OF GROUP BENEFITS
PLAN NUMBER (PN):	501
TYPE OF PLAN:	Group Major Medical Benefit Plan
FUNDING MEDIUM AND TYPE ADMINISTRATION:	The Plan is a self-funded Group Health Plan. Benefits are administered on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administrative Services Agreement and the terms and conditions of the Benefit Plan. The funding for the Benefits is derived from the general assets of the Employer or and contributions made by covered Employees. Employee contributions are at a rate determined by the Plan Sponsor. The Plan is not insured.
PLAN ADMINISTRATOR:	Office of Group Benefits Post Office Box 44036, Baton Rouge, Louisiana 70804
AGENT FOR SERVICE OF LEGAL PROCESS:	Service for legal process may be made upon the Plan Administrator.
CLAIMS ADMINISTRATOR:	Blue Cross and Blue Shield of Louisiana (BCBSLA) 5525 Reitz Avenue Baton Rouge, LA 70809 (225) 295-3307 BCBSLA has been hired to process claims under the Plan. BCBSLA does not serve as an insurer, but merely as a claims processor. Claims for Benefits are sent to BCBSLA. BCBSLA process and pays claims, then requests reimbursement from Plan. Office of Group Benefits is ultimately responsible for providing plan Benefits, and not BCBSLA.
PLAN YEAR ENDS:	December 31st
PLAN DETAILS:	The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any Benefits are described in the Benefit Plan.
FUTURE OF THE PLAN:	Although the Plan Sponsor expects and intends to continue the Benefit Plan indefinitely, the Group reserves the right to modify, amend, suspend, or terminate the Benefit Plan at any time.