

GROUP HEALTH BENEFITS

FOR THE EMPLOYEES OF



LOUISIANA SHERIFFS' ASSOCIATION
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Administered by



**BlueCross BlueShield
of Louisiana**

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**LOUISIANA SHERIFFS' ASSOCIATION
SCHEDULE OF BENEFITS
COMPREHENSIVE MAJOR MEDICAL PLAN DOCUMENT**

Group's Anniversary Date: July 1

Group's Amended Benefit Plan Date: July 1, 2008

Benefit Period..... Calendar Year

Lifetime Maximum Benefit..... \$5,000,000.00

Automatic Restoration Maximum (per Benefit Period)\$2,000.00

Benefit Period Deductible Amount

(Employees and Covered Dependents)

Per Member\$500.00

Aggregate Deductible per Family\$1,500.00
(Individual Deductible need not be met to qualify for aggregate)

Inpatient Deductible per member per Admission\$250.00

The Benefit Period Deductible Amount does not apply to the following:
On-the-Job Accidental Injuries

(Retirees and Covered Dependents without Medicare Part A and B)

Per Member\$1,000.00

Aggregate Deductible per Family\$3,000.00
(Individual Deductible need not be met to qualify for aggregate)

Inpatient Deductible per Member per Admission\$250.00

Coinsurance:

Subject to the Deductible Amount, the Group will pay the Coinsurance percentage(s) shown below of the Allowable Charge for Covered Services described in the Plan Document.

	<u>Preferred Care Provider</u>	<u>Other Provider</u>
All eligible Covered Services	80% / 20%	60% / 40%
On-the-Job Accidental Injuries for Employees	100% / 0%	100% / 0%

Out-of-Pocket Amount

Preferred Care Provider.....\$3,000.00

Other Provider\$5,000.00

Once the Out-of-pocket Amount is reached, Benefits of one hundred percent (100%) of the Allowable Charge will be paid for Covered Services, except as noted in the Plan Document.

Coinsurance for mental and nervous benefits is **not** eligible for satisfying the out-of-pocket amount. The out-of-pocket amount for preferred care providers is eligible for satisfying the out-of-pocket amount for other providers and visa versa.

Mental Disorders

Aggregate Benefit Period Maximum\$10,000.00

Coinsurance	<u>Preferred Care Provider</u>	<u>Other Provider</u>
Inpatient Professional Services	80% / 20%	60% / 40%
Inpatient Hospital Services	80% / 20%	60% / 40%
Outpatient Services (Maximum 52 outpatient visits per benefit period)	50% / 50%	50% / 50%

Rehabilitation Services:

Speech Therapy is limited to twenty (20) visits per Benefit Period

Alcohol and/or Drug Abuse	80% / 20%	60% / 40%
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Inpatient hospital or psychiatric facility to be paid same as any other illness. Approved chemical dependency facility limited to a maximum of 28 days per 48 month period.

Hospice Care

Benefits are available only when Authorized and have a lifetime maximum of one hundred eighty (180) days.

Skilled Nursing Facility Care

Sixty (60) days maximum, renewable if confinement period is separated by six months. Admission must follow minimum Hospital stay of 3 days and must be within 14 days of discharge from Hospital.

Dental Surgical Benefits

Treatment for eligible dental services is as described in the Plan Document. Treatment must begin promptly after injury to sound natural teeth.

Organ Transplant(s)

Lifetime Maximum (Includes all acquisition costs).....\$300,000.00

Prescription Drug Benefit:

A \$100.00 calendar year Prescription Drug Deductible Amount will apply prior to the application of Prescription Drug Co-payments.

	<u>Retail 34 Day Supply</u>	<u>Mail Order 90 Day Supply</u>
Generic	\$10.00	\$30.00
Preferred Brand	\$30.00	\$90.00
Non-Preferred Brand	\$45.00	\$135.00
Multi Source Brand	\$55.00	\$165.00
Injectible Brand	\$50.00	(no mail order for 5 tier injectable)

Your plan offers a five-tier copayment structure for covered medications. You will pay the lowest copayment when you use generic drugs (Tier 1) and the highest copayment for multi-source brand (Tier 4) and injectable medications (Tier 5). Tier classifications are described as follows:

1. Tier 1 - A Prescription Drug that is a Generic Drug.
2. Tier 2 - A Prescription Drug that is a Brand-Name Drug.
3. Tier 3 - A Prescription Drug that is a Brand-Name Drug that may have a therapeutic alternative as a Tier 1 or Tier 2 drug. Covered compounded drugs are included in this Tier.
4. Tier 4 - A Brand-Name Drug for which a Generic equivalent is available (i.e. - Multi-Source Brand Drug).
5. Tier 5 - Injectable Prescription Drugs include those medications that are intended to be self-administered. However, insulin and injectable antihemophilic Prescription Drugs may be included in another drug tier.

THE FOLLOWING CATEGORIES OF PRESCRIPTION DRUGS REQUIRE PRIOR AUTHORIZATION. IF THE PRESCRIPTION DRUG REQUIRES PRIOR AUTHORIZATION, YOUR PHYSICIAN MUST CALL 1-800-376-7741 TO OBTAIN THE AUTHORIZATION. CALL THE CUSTOMER SERVICE TELEPHONE NUMBER ON YOUR ID CARD TO SEE IF THE CATEGORIES OF PRESCRIPTION DRUGS REQUIRING PRIOR AUTHORIZATION HAVE CHANGED:

Specialty Drugs/Biotechnology Medicines - Examples include, but are not limited to:

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

Controlled Dangerous Substances - Examples include, but are not limited to:

- **Schedule II Drugs***

*** Shall include all drugs that are in this category.**

BENEFITS WILL NOT BE PAID FOR THESE PRESCRIPTION DRUGS UNLESS PRE-AUTHORIZATION IS OBTAINED.

NOTE: Specialty Drugs may be limited to a 34 day supply for both retail and mail order prescriptions. Benefits are available for contraceptive drugs including the following contraceptive injections: Norplant Implants and Depoprovera Injections. Please check your certificate for additional information concerning prescriptions drugs.

AUTHORIZATION

Authorization of Inpatient and Emergency Admissions:

For all Inpatient Admissions, application for Pre-Admission Authorization, Emergency Admission Authorization or Continued Stay Review must be made to Blue Cross and Blue Shield of Louisiana by calling:

In Baton Rouge 295-2347
All Other Areas 1-800-523-6435

Penalty if Pre-Admission Authorization or an Emergency Admission Authorization is not requested: Benefits will be reduced by fifty percent (50%) - Refer to the “Authorization” section in the Plan Document for complete information.

Authorization of Other Covered Services and Supplies:

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

- Home Health Care
- Hospice Care
- PET Scans

Please note:

Blue Cross and Blue Shield of Louisiana provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

New Customer Service E-Mail Address – Help@bcbsla.com

Blue Cross and Blue Shield of Louisiana has consolidated its customer service e-mails into a single, easy-to-remember address: help@bcbsla.com. Customers who need to contact Us 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 Us,” found at the upper right of every web page.

**LOUISIANA SHERIFFS’ ASSOCIATION
COMPREHENSIVE MAJOR MEDICAL PLAN
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ARTICLE I DEFINITIONS

The terms set out below, wherever used in this Plan shall be construed as follows:

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

Administrator - means the person responsible for the daily management of the Plan. For purposes of this Plan, the Administrator is the Insurance Advisory Committee of the Louisiana Sheriffs' Association Group Benefits Plan.

Admission - means an uninterrupted period of time spent as an Inpatient in a Hospital or a convalescent home.

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

Ambulatory Surgical Facility - means a facility physically disassociated with any other institution (e.g., Hospital) providing surgical and/or medical care, whose sole purpose is to offer and provide a professional setting for the performance of a Cutting or Operative Procedure to its patients. Said facility shall not engage in any active bed patient care (i.e., overnight) or be a substitute setting for care routinely and/or normally provided in a Physician's office or clinic setting.

Approved Treatment Facility - means an institution which does not qualify as a Hospital (as defined), but which does provide a program of effective medical and therapeutic treatment for alcoholism, drug addiction, or the use of any hallucinogenics, and where coverage of such treatment meets all the following requirements:

- A. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
- B. It provides a program of treatment under the care of a Physician.
- C. It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- D. It provides at least the following basic services:
 - (1) Room and board;
 - (2) Evaluation and diagnosis;
 - (3) Counseling; and
 - (4) Referral and orientation to specialized community resources.

Authorization (Authorized) - A determination that We make regarding an Admission, continued Hospital stay, or other health care service or supply for the purpose of determining Medical Necessity, appropriateness of the setting, or level of care. An Authorization is not a guarantee of payment.

Benefit Period - means a calendar year beginning January 1 and ending December 31 of the same year.

Child - means a stepchild, foster child, and any other child natural or adopted who:

- A. Lives with the Covered Person in a normal parent-child relationship and depends upon the Covered Person for principal support and maintenance; or

B. Is of a previous marriage for which child support payments are being made by the Covered Person.

NOTE: The Plan reserves the right to require proof that the Child was filed as a Dependent on the Covered Person's Federal Income Tax return.

Continued Stay Review - means the process used to certify the appropriate length of a Hospital confinement as a registered bed patient.

Controlled Dangerous Substances – A drug or substance, or immediate precursor, included in schedules I through V of the Controlled Substances Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Convalescent Care - means Medically Necessary health care rendered in a Skilled Nursing Facility.

Cosmetic Surgery - means such surgery to include cosmetic, plastic and reconstructive surgery; and complications thereof and/or associated conditions.

Covered Person - means the Employee/Retiree who has been accepted by the Plan for participation and all eligible Dependents.

Custodial Care - means care designed essentially to assist an individual to meet the activities of daily living (i.e., services which constitute personal care such as help in walking, getting in and out of bed, assisting in bathing, dressing, feeding, using the toilet) and care which does not require Admission to a Hospital, or other institution, or locality, for the treatment of an illness, injury, or for the performance of surgery; or, care primarily to provide room and board (with or without routine nursing care, training in personal hygiene and other forms of self-care) and supervisory care by a doctor for a person who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care, or when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Cutting or Operative Procedure - means use of an instrument to disrupt the continuity of, or to cut into, or through, the body, or surface of a body opening (e.g., mouth, nose, rectum, vagina, bladder).

Deductible - means a designated portion of the expense or charge for a medical or dental service provided under this Plan, which portion must be paid by the Employee/Retiree to the provider of service.

Dentist - means a Doctor of Dental Surgery or Doctor of Dental Medicine who is legally qualified and licensed to practice dentistry at the time and place dental services are rendered.

Dependent - means the legal spouse of an Employee/Retiree, and any unmarried Child who meets the following conditions:

A. Is a natural Child; or

B. Is a legally adopted Child (Note: an adopted Child who is awaiting final order of adoption is an eligible Dependent from the date the Child is placed in the Employee's home), foster child, stepchild, grandchild, or other child who both (i) lives with the Employee in a regular parent-child relationship and (ii) is dependent upon the Employee for principal financial support. Any natural or adopted Child of a previous marriage for which child support payments are being made is considered as an eligible Dependent.

- C. Is less than twenty-one (21) years of age. However, a Child who is principally dependent upon the Employee for support (depends on the Employee for more than half of the Child's support) and who is enrolled on a full-time basis in an accredited college or university, or a vocational, technical, vocational-technical, or trade school or institute, or secondary school, shall be considered a Dependent until attainment of twenty-five (25) years of age. For coverage to be continued during vacation periods, the covered Dependent must be scheduled to enter school on the next enrollment date.
- D. Any mentally retarded or physically handicapped Child shall remain covered beyond the maximum age provided the unmarried Child satisfied the requirements of (a) and (b) above; became mentally or physically disabled before age twenty-one (21) or twenty-five (25) if a covered student; and is incapable of self-sustaining employment and is chiefly dependent upon the Employee for support and maintenance. Proof of incapacity must be furnished and additional proof may be required from time to time. "Disabled" means any medically determinable physical or mental condition which prevents the Child from engaging in self-sustaining employment; provided that the disability commences prior to such Child's attainment of the limiting age and that satisfactory proof of such disability and dependency is submitted by the Employee within thirty-one (31) days following the Child's attainment of the limiting age.

NOTE: No coverage will be made effective for a Child other than a natural Child until the Employee has submitted documentation which satisfies the Committee that both (a) a parent-child relationship exists, and (b) the Employee provides principal financial support for that Child.

Diagnostic Admission - means an Admission to a Hospital of a patient whose condition:

- A. Does not require constant availability of medical supervision by the attending Physician or other medical staff;
- B. Does not require constant availability of licensed nursing personnel for skilled nursing care;
- C. Could have utilized diagnostic and/or therapeutic services and equipment as an Outpatient.

Durable Medical Equipment - means equipment designed for repeated use and which is Medically Necessary, as determined by peer review, for the treatment of an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes items such as wheelchairs, Hospital beds, respirators, braces and other items that the Plan may determine to be Durable Medical Equipment, excluding transportation devices (e.g., automobiles, vans, and airplanes).

Eligible Medical Expense - means the Allowable Charges actually incurred for Medically Necessary Health Care, when such care is prescribed and/or rendered by a Physician for the diagnosis and/or treatment of a sickness or injury.

Employee - means a person employed on a full-time (thirty (30) hours per week) permanent basis by the Employer.

Employer - means each Parish Sheriffs' Department, the Louisiana Sheriffs' Association Executive Office, and the Louisiana Sheriffs' Association Pension & Relief Fund Office, when such groups have been accepted by the Plan for participation.

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

Health Care - means any Medically Necessary service provided under the terms of the Plan.

Home Health Care - means health services rendered in the individual’s place of residence by an organization licensed as a home health care agency by the appropriate state agency and approved by the Third Party Administrator. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual’s place of residence, skilled nursing services by or under the supervision of a registered nurse licensed to practice in this state.

Hospital - means an institution licensed by the state in which it operates with: A governing board legally responsible for the conduct of the institution; an administrator to whom the governing authority delegates the full-time responsibility for the operation of the institution in accordance with established policy; and organized medical staff to which the governing authority delegates responsibility for maintaining proper standards of surgical and medical care; current and complete medical records of each patient; pharmacy, diagnostic x-ray, clinical laboratory and anatomical pathology, and operating room services with facilities and staff for a variety of procedures; and food service meeting the nutritional requirements of the patients.

The term “Hospital” further means an institution which, for compensation from its patients: is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnostic, treatment and care of the injured and sick persons by or under the supervision of a staff of Physicians who are licensed to practice medicine; provides twenty-four (24) hour a day nursing service by registered graduate nurses; and is not, other than incidentally, a place of the aged or for rehabilitation, for treatment for pulmonary tuberculosis, drug addicts, and alcoholics, or an extended care facility or a medical training institution.

Inpatient - means a person confined to bed in a Hospital or a Skilled Nursing Facility.

Medically Necessary - means a service or treatment which, in the judgment of the Plan:

- A. Is appropriate and consistent with the diagnosis and which in accordance with accepted medical standards on the state of Louisiana, could not have been omitted without adversely affecting the patient’s condition or the quality of medical care rendered; and
- B. Is not primarily Custodial Care; and
- C. As to institutional care, could not have been provided in a Physician’s office, in the Outpatient department of a Hospital, or in a lesser facility without adversely affecting the patient’s condition or the quality of medical care.

Medicare - means all applicable provisions of Title XVIII of the Social Security Act of 1965 as constituted and amended.

Member – An Employee or an enrolled Dependent.

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

Non-Occupational Disease - means a disease that does not arise out of (or in the course of) any work for pay

or profit, nor in any way results from a disease, which does. However, if proof is furnished that the Covered Person is covered under a Worker's Compensation law or similar law, but is not covered for a particular disease under such law, that disease will be considered "Non-Occupational" regardless of the cause.

Non-Occupational Injury - means an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an injury which does.

Occupational Accidental Injury - means an accidental bodily injury that arises out of (or in the course of) any work on behalf of the Sheriff's Department for pay.

Out-of-Pocket Amount - means the portion of coinsurance that is payable by the Covered Person before the Plan's coinsurance increases to one hundred percent (100%).

Outpatient - means a person who is not admitted as an Inpatient, but who receives Health Care.

Part-Time Employee - means a person employed on a part-time basis (less than thirty (30) hours per week) who may or may not receive pay for such work.

Physical Therapy - means the evaluation of physical status as related to functional abilities and treatment procedures as indicated by that evaluation. Such therapy is therapy provided by a registered physical therapist who is licensed to practice in the state where the service was rendered. Services provided must meet the following criteria: ordered by a Physician; requires the skills of a registered physical therapist; performed by or under direct supervision of a physical therapist; restorative potential exists; meets the standards for medical practice; reasonable and necessary for treatment of the illness, injury or post-operative condition.

Physician - means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed without limitation to practice medicine or perform surgery at the time and place the service is rendered. For services covered by this Plan only, doctors of dental surgery (D.D.S.), doctors of podiatric medicine (D.P.M.), doctors of chiropractic (D.C.), and doctors of optometry (O.D.), when acting within the scope of their licenses, are deemed to be Physicians. No practitioners other than those specified above shall be deemed to be Physicians for purposes of the Plan. Physician does not include interns, residents, fellows, or others enrolled in a residence training program.

Plan - means the Louisiana Sheriffs' Association Group Benefits Plan, effective as of May 1, 1983.

Pre-Existing Condition - means any sickness or injury for which the Covered Person has received medical care or taken prescribed drugs during the twelve (12) months immediately prior to his or her effective date under this Plan.

Prescription Drug Co-payment - The amount that a Member must pay for each prescription and which may be collected directly from a Member at the time a prescription is filled. A different Prescription Drug Co-payment may be required for generic, preferred brand, and non-preferred brand Prescription Drugs purchased at retail and through the mail.

Prescription Drug Deductible Amount - The dollar amount, as shown in the Schedule of Benefits, which must be paid by a Member within a calendar year prior to any applicable Prescription Drug Co-payment or coinsurance percentage.

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 contained herein.

Private Duty Nursing - means Medically Necessary, as determined by peer review, services requiring the technical proficiency and scientific skills of a registered nurse or licensed practical nurse which must be (a) provided on a standard shift basis (eight (8) hours of care per shift); (b) ordered by an attending Physician; and (c) other than for the convenience of the patient or for the patient's family.

Rest Cures - means care provided in a sanitarium.

Restatement Date - means January 1, 2000.

Retiree - means a former Employee who meets the retirement criteria specified by the Employer.

Sanitarium Care - means care designed to provide custodial services and provide for the mental and physical well-being of an individual.

Similarly Situated Beneficiary - means a person, or persons, with like coverage (i.e., Employee only, Employee and spouse, Employee and Child(ren), Employee and family, etc.) regardless of that person's coverage status.

Skilled Nursing Facility - means an institution approved to provide the specific level of care as so defined by Medicare.

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.

Spinal Manipulative Therapy - means the practice or procedure by which the hands or any instrument or device are used to adjust, mobilize, manipulate, massage, stimulate or otherwise influence the spine and the adjacent or nearby muscles, ligaments, nerves and tissues, for the purpose of diagnosis, treatment or otherwise improving a Covered Person's physical or mental condition.

Third Party Administrator - means the firm with whom the Administrator has contracted to handle the claims and billing function of the Plan. For purposes of this Plan, the Claims Administrator is Blue Cross and Blue Shield of Louisiana.

Totally Disabled - means:

- A. For a covered Employee, the inability to engage in his or her occupation.
- B. For a covered Dependent, the inability to engage in his or her customary duties and activities.

ARTICLE II ELIGIBILITY AND TERMINATION

A. Active Full-Time Employees

Employee - means a person employed on a full-time (thirty (30) hours per week) permanent basis by the Employer.

B. Part-time and Reserve/Auxiliary Deputies

Part-time and Reserve/Auxiliary Deputies who are commissioned and who work regularly on a part-time basis (less than thirty (30) hours per week) are eligible for specific coverage as defined herein based on individual Parish option. Dependents of such deputies are not eligible for coverage under the Plan.

C. Retirees

The following Retirees are eligible to participate in the Plan:

1. Retirees currently receiving benefits under the Association Pension Plan who have:
 - a. Joined the Plan during the ninety (90) days after their parish joined the Medical Plan;
 - b. Exercised their option to continue coverage under the Medical Plan in the thirty (30) days from the date they ceased to be a full-time Employee.

If such election is not made in the thirty (30) day option period or if the Retiree declines coverage, or drops coverage at any time after retirement, such person will not again be eligible to participate at any time in the future.

2. Employees who have qualified for retirement by years of service, but not by age (Deferred Retirees), who have:
 - a. Joined the Plan during the ninety (90) days after their parish joined the Medical Plan; or
 - b. Exercised their option to continue coverage under the Plan in the thirty (30) days from the date that they ceased to be an active full-time Employee.

If such election is not made in the thirty (30) day option period or if the Deferred Retiree declines or drops coverage from the date he or she ceased to be eligible as an active full-time Employee, such person will not again be eligible until the date he or she becomes eligible to draw retirement benefits. On that date, he or she may become eligible to participate in the Medical Plan, but will be required to show evidence of good health before acceptance, and application must be made within thirty (30) days of the date the Retiree becomes eligible.

3. Former Employees who did not qualify for retirement, but had accumulated twelve (12) or more years of full-time service, who have exercised their option to continue coverage under the Plan within thirty (30) days from the date they ceased to be an active full-time Employee.
4. Employees who have qualified for retirement by years, but not by age, who have exercised their right to join the program during the ninety (90) day open enrollment or have exercised their option to

continue under the Plan, and their Dependents as defined in ARTICLE I, DEFINITIONS, are eligible to participate in the Plan.

Dependents covered by the Retiree the day prior to retirement, may be included by Retirees only on the Retirees' initial effective date of coverage. A Retiree may not add Dependent coverage at a date later than his or her initial date of coverage unless adding a new spouse within 30 days of marriage, or adding a Dependent child within 30 days of eligibility.

5. To comply with House Bill 253, Act 314 of 1999 which provides "the premium costs of group hospital, surgical, medical expenses, and dental insurance and the first ten thousand dollars of life insurance contracted under the provisions of this Section shall be paid in full from the sheriff's general fund for all sheriffs and deputy sheriffs retired with a minimum of fifteen years service and are fifty-five years of age," effective April 1, 2000 the Plan will open participation to Retirees of Sheriff Offices participating in the Louisiana Sheriff's Association's Medical, Dental and Life Plan who were not eligible for coverage upon retirement. Participation is further limited to Retirees of the parishes that are enumerated in Act 314 of 1999. This open enrollment period is from April 1, 2000 through April 30, 2000 for an effective date of April 1, 2000. Coverage into the Plan is for the Retiree only and does not include dependents.

D. Employee - Initial Eligibility Date

1. Each Employee whose employment commenced on or before the effective date of this Plan shall become eligible for coverage on the effective date of this Plan.
2. Each Employee whose employment commences after the effective date of this Plan shall become eligible for coverage on his or her date of employment, provided application for coverage has been made by that date. If application for coverage is made within one (1) month after the date of employment, coverage will become effective on the date application is made.

E. Dependent - Initial Eligibility Date

1. Each eligible Dependent of an Employee or Retiree whose employment commenced on or before the effective date of this Plan shall become eligible for coverage on the effective date of this Plan.
2. Each eligible Dependent of an Employee whose employment commences after the effective date of this Plan shall become eligible for coverage on the Employee's date of employment, or, if later, the date the Employee makes application for Dependent coverage, provided such application is made within one (1) month after the Dependent's initial eligibility date.
3. A Dependent Child who is ordered by the court to be covered under the Plan will be eligible for coverage when required by such court or administrative order, to comply with the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). This Plan will automatically be amended to include any change or interpretation to such law.
4. Adding Newborn Children to Coverage

The Employee must notify the Third Party Administrator that the Employee is adding a child and the effective date of coverage. If the Third Party Administrator is notified within thirty (30) days of the date the child becomes eligible, the child's effective date will be the date the child became eligible. If the Third Party Administrator is not notified within thirty (30) days of the child becoming eligible for

coverage, then evidence of good health requirements will apply. Once approved, the effective date will then be the first of the month following the date the change card was notarized.

- F. In the event an Employer not participating in the Plan on the original effective date of the Plan begins participation subsequent to the effective date, any Participants in that Employer's group insurance plan on the day immediately preceding participation in this Plan shall be eligible for immediate coverage and:
1. There will be no Pre-Existing Conditions exclusion applicable to such participants;
 2. Expenses applied toward the Deductible and Out-of-Pocket provisions of the prior plan shall be applied toward the Deductible and Out-of-Pocket provisions of this Plan, provided however,
 3. Any benefits otherwise payable under this Plan shall be reduced by any benefits payable under the extended benefits provisions of the prior plan.
- G. An Employee not enrolling self or Dependents as defined in ARTICLE I, DEFINITIONS, during their initial period of eligibility will be required to show proof of insurability. The effective date of coverage will be the first day of the month following the date the application or change card is notarized.

Acceptance or rejection of such application will be made by the Plan at its discretion based on the evidence of good health submitted. The type and form of required proof of good health will be determined by the Plan. The Employee will be required to pay the cost of obtaining such proof.

H. Actively At Work/Non-Confined Requirement

1. The effective date of coverage for an Employee not actively at work on his or her initial eligibility date will be deferred until the date he or she returns to active full-time employment.
2. The effective date of coverage for a Dependent who is confined, because of disease, illness, or injury, at home, in a nursing home, Hospital, or elsewhere on his or her initial eligibility date will be deferred until his or her confinement or disability ends.

This provision will not apply to a newborn Child for whom coverage has previously been applied for or who is the Dependent of an Employee already enrolled for Child or family coverage.

- I. Dependents, as defined in ARTICLE I, DEFINITIONS, of an Employee who are covered at the time of the Employee's death are eligible as follows:
1. If the Employee is killed in the line of duty, eligibility continues as though the Employee had not died.
 2. If an Employee with twelve (12) or more years service dies, his or her Dependents will be eligible to continue coverage as though the Employee had not died.
 3. If an Employee with five (5) years, but less than twelve (12) years of service dies other than in the line of duty, his or her Dependents will be eligible to continue participation in the Plan for two (2) years after the Employee's death.
 4. If an Employee with less than five (5) years of service dies other than in the line of duty, his or her Dependents will be eligible to continue participation in the Plan for one (1) year after the Employee's death.

Dependents have thirty (30) days after the death of an Employee or Retiree to make a decision as to continuation of coverage. After thirty (30) days, Dependents will be dropped from the Plan and will not again be entitled to coverage.

- J. If an Employee's employment terminates for reasons other than (a) retirement, or (b) termination of the Plan, the coverage terminates at midnight on the day employment terminates; however:
1. If the Employee is granted a leave of absence because of the inability to work due to an on-the-job injury or a disease contracted while on the job, coverage may continue for up to twelve (12) months during such leave.
 2. If the Employee is granted a leave of absence for a work related leave of absence not defined in (1) above, (i.e., law enforcement education, sickness, off-the-job injury, work suspension, etc.), coverage may continue for up to six (6) months during such leave. Exception to the six (6) month extension is that an Employee who takes a leave of absence to run for Sheriff and is elected, can remain on the Plan under this extension for longer than six (6) months, until such time that he takes office or rejoins the department. At such time he or she will be considered an active Employee.
 3. If the Employee is granted a leave of absence for any reason not defined in (1) or (2) above, coverage may continue for up to ninety (90) days.
 4. **NOTE:** The following shall apply to Employers who are subject to the Family Medical Leave Act (FMLA) of 1993.
 - a. If the Employee qualifies under the Act to take a Family Medical Leave, the twelve (12) week entitlement under the FMLA will apply against any other continuation provision in this Plan.
 - b. This Plan will comply with the continuation and reinstatement provision of the said Act.

The continuation of coverage as stated above is in addition to COBRA.

K. Special Transfer Provision

In the event an Employee's employment with a participating Employer terminates and the Employee begins employment with another participating Employer on the next regularly scheduled work day after termination of coverage with the original Employer, the coverage status for the Employee and any covered Dependents will be transferred in place; i.e., no new Pre-Existing Condition limitation will apply and credit will be given for expenses previously applied toward satisfaction of current Deductible and Copayment. Any eligible Dependents who were not covered under the former participating Employer and who apply for coverage under the new participating Employer will be subject to the evidence of good health requirement of Section G of ARTICLE II, ELIGIBILITY AND TERMINATION.

In the event employment with another participating Employer begins later than the next following regularly scheduled work day following termination of coverage with the original Employer, the Employee will be considered to be a new Employee and the provisions of ARTICLE XI, PRE-EXISTING CONDITIONS will apply.

ARTICLE III COBRA CONTINUATION OF COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and any amendments thereto, certain covered Employees and Dependents who would otherwise lose coverage as a result of a qualifying event, will have the option of continuation of that coverage without evidence of insurability.

These Employees and Dependents (“qualified beneficiaries”) are those who are covered under this Benefit Plan on the day before a qualifying event occurs. In addition, a child who is born or placed for adoption with the covered Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary if notification of such birth or adoption is made within thirty (30) days of birth or adoption.

A “qualifying event” is any of the following events:

- Termination of employment of a covered employee for reasons other than gross misconduct;
- Loss of eligibility by a covered employee due to a reduction in the number of work hours of the covered employee;
- Death of a covered Employee;
- A Dependent spouse’s divorce or legal separation from a covered Employee;
- The covered Employee becomes entitled to Medicare benefits resulting in the loss of coverage for Dependents; or
- A Dependent child ceases to be an Eligible Dependent under the terms of this Benefit Plan.
- The employer’s Title 11 bankruptcy proceeding, with respect to covered employees who retired from the employer at any time.

The qualified beneficiary must notify the Group plan administrator if the qualifying event is a divorce or legal separation or if a Dependent child loses eligibility for coverage, within sixty (60) days of the occurrence of the qualifying event.

The employer will advise a qualified beneficiary of his or her rights under COBRA upon the occurrence of any other qualifying event and following notice or occurrence of a qualifying event when such notice is required to be given by the qualified beneficiary.

A Member may be required to pay the applicable premium for continued coverage plus an amount to cover administrative expenses. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Member otherwise would lose coverage under the group health plan (the termination date); and
- ends no earlier than sixty (60) days after the termination date or if timely notice by a Member must be given, sixty (60) days after the Member is notified of their right to continue coverage.

If continuation of coverage is elected, the qualified beneficiary then has forty-five (45) days within which to make the first premium payment.

Continuation of coverage begins on the termination date and ends no earlier than:

- eighteen (18) months after the termination date in the case of termination of employment or reduction in work hours. If a second qualifying event, other than bankruptcy occurs during this eighteen (18) month period, the eighteen (18) month period may be extended to thirty-six (36) months. Where the qualifying event is entitlement of a covered Employee to Medicare during the eighteen (18) month period preceding the termination of employment or reduction in hours of employment, the period of coverage for Dependents of that Employee shall terminate on the later of thirty-six (36) months from the date the Employee becomes entitled to Medicare or eighteen (18) months from the termination of employment or reduction in hours of employment.

Note: The eighteen (18) months may be extended to twenty-nine (29) months if a qualified beneficiary who is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) before the first day of COBRA coverage or becomes disabled during the first sixty (60) days of COBRA coverage. This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. The qualified beneficiary must notify the Group plan administrator of the disability determination no later than sixty (60) days from the date of the Social Security Administration determination and before the end of the original eighteen (18) month period. The qualified beneficiary must also notify the employer within thirty (30) days of any final determination that the qualified beneficiary is no longer disabled. In this case, coverage will end the earliest of twenty-nine (29) months after the date of the qualifying event or the first day of the month that begins more than thirty (30) days after a final determination that the qualified beneficiary is no longer disabled (as determined under the Social Security Act) subject to the original eighteen (18) months of COBRA coverage; or

- thirty-six (36) months after the date of termination due to any other qualifying event; or
- the date the employer ceases to maintain any group health plan; or
- the date coverage ceases because of non-payment of required premiums; or
- the date the Employee or Dependent first becomes covered after the date of the COBRA election under another group health plan and benefits under that plan are not excluded or limited with respect to a Pre-Existing Condition; or
- the date the Employee or Dependent becomes entitled to Medicare after the date he or she elects COBRA coverage.

Note: Special rules apply for the duration of coverage under COBRA for certain Retirees and their Dependents who lose coverage as a result of an employer's bankruptcy, which is a "qualifying event." In this event, affected Retirees may elect lifetime COBRA coverage as of the date of the bankruptcy proceeding. Dependents of Retirees may continue COBRA coverage until the Retiree's death. When the Retiree dies, Dependents of Retirees may elect an additional thirty-six (36) months of coverage from the date of the Retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including: the employer ceases to provide any group health plan to any employees or the qualified beneficiaries fail to

pay the required premiums or become covered under another employer's group health plan that does not exclude or limit benefits for a qualified beneficiary's Pre-Existing Conditions.

Note: 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 assistance (TAA)" or "alternative trade adjustment (ATAA)" under a federal law called the Trade Act of 2002. 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 begins 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 Member qualifies or may qualify for assistance under the Trade Act of 2002, the Member should contact his 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 OR THE MEMBER WILL LOSE HIS SPECIAL COBRA RIGHTS.**

ARTICLE IV LIMITATIONS AND EXCLUSIONS

- A. Services, supplies and treatment for services that are not covered under this Benefit Plan and complications from services, supplies and treatment for services that are not covered under this Benefit Plan are excluded.
- B. Any of the limitations and exclusions listed in this Benefit 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 Member has no obligation to pay, or for which no charge would be made if a Member had no health insurance coverage;
 - b. rendered or furnished before the Member's Effective Date. Charges for Hospital services or supplies rendered or furnished during an Admission in progress on the date the Member's coverage under the Benefit Plan ends will be covered until the date that coverage ends. The Member will not receive Benefits for any charges incurred after the date coverage ends. Hospital Benefits will be provided for an Admission in progress on the date a Member's coverage under this Benefit Plan ends, until the end of that Admission, or until a Member has reached any Benefit limitations set in this Benefit Plan, whichever occurs first;

- c. which are not prescribed by or performed by or upon the direction of a Physician or Allied Health Professional acting within 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, and except for limited benefit policies;
 - e. paid or payable under Medicare Parts A or B when a Member 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 Our policies and procedures for such determinations which are on file with the Louisiana Department of Insurance;
 - g. Workers' Compensation and injuries as a result of riots or civil disobedience are not exclusions for the Employee only while on duty. These remain exclusions for Employees off duty and for Dependents at all times;
 - h. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; or
 - i. ordered, prescribed, or rendered by a Provider who is related to a Member by blood, marriage or adoption, or who regularly resides in a Member's household.
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 Member's commission or attempted commission of a felony; or
 - e. for treatment of any Member confined in a prison, jail, or other penal institution.
6. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from 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 services as specifically provided in this Benefit Plan;
 - e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants;
 - f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;

- g. diastasis recti;
 - h. biofeedback;
 - i. lifestyle/habit changing clinics and/or programs;
 - j. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies.
 - k. industrial testing or self-help programs (including, but not limited to, smoking cessation programs and supplies, and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations; and/or
 - l. recreational therapy;
 - m. primarily to enhance athletic abilities; and/or
 - n. Inpatient pain rehabilitation and pain control programs.
7. Services, Surgery, supplies, treatment, or expenses related to:
- a. routine eye exams, eyeglasses or contact lenses or exams (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered in the Schedule of Benefits;
 - 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 Member 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; 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.
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. Services or supplies for the treatment of eating disorders, unless otherwise required by law.
12. No Benefits will be provided under this Benefit Plan for any charges incurred for any Pre-Existing Condition as described in Article XI.
13. Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits:
 - a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Meridia®, Xenical®), or medications used to enhance athletic performance;
 - b. any medication not proven effective in general medical practice;
 - c. 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 as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug;
 - d. fertility drugs;
 - e. minerals and vitamins, except for vitamins requiring a prescription for dispensation;
 - f. nutritional or dietary supplements, or herbal supplements and treatments;
 - g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available.
 - h. contraceptive devices;
 - i. refills in excess of the number specified by the Physician or the dispensing limitation described in this Benefit Plan, or a refill prior to seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription;
 - j. any drugs used for smoking cessation except Zyban;
 - k. compounded drugs that exhibit any of the following characteristics: 1) are similar to a commercially available product; 2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval; 3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being administered topically); 4) compounded drugs that contain drug products or components of such drug products that have been withdrawn or removed from the market for reasons of safety; or 5) compounded prescriptions whose only ingredients do not require a prescription;
 - l. drugs for non-Covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®);
 - m. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;
 - n. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage;
 - o. Prescription Drugs related to a non-Covered Service;

- p. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®);
 - q. Medication, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner;
 - r. growth hormone therapy, except for chronic renal insufficiency, AID's wasting, and Turners Syndrome, unless an endocrinologist confirms growth hormone deficiency with abnormal provocative stimulation testing; or
 - s. Prescription Drugs for and/or treatment of idiopathic short stature.
 - t. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Member misrepresentation to that prescriber. Limitation may include, but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy.
14. Coverage is not available for self-administered Prescription Drugs (e.g., oral or self-injectable drugs) when obtained from a Physician or other Provider who is not contracted with Our pharmacy benefit manager. Injectable drugs that can be self-administered are not covered when obtained from an infusion therapy provider, unless prescribed in conjunction with intravenous infusions provided by the infusion therapy provider.
 15. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Member's Coinsurance and Our financial responsibility. We will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Member's Copayment, in which case, the Member must pay the Prescription Drug cost and sales tax.
 16. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Member's home or vehicle.
 17. Charges for telephone or e-mail Consultations between a Provider and a Member, 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. Palliative or cosmetic foot care; care of flat foot conditions; supportive devices for the foot, except when used in the treatment of diabetic foot disease; care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints related to the feet.
 19. Any abortion other than to save the life of the mother.
 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. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.

23. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.
24. Services, supplies or treatment for cosmetic purposes, Cosmetic Surgery and any complications of Cosmetic Surgery, unless required for a Congenital Anomaly.
25. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits.
26. Diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition.
27. 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.
28. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.
29. 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.
30. 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.
31. Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.
32. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.
33. Hospital charges for a well newborn.
34. Services or supplies for the treatment of alcohol and/or drug abuse, unless shown as Covered Services in the Schedule of Benefits.
35. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
36. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan.
37. Surgical and medical 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 Member.
40. Reversal of a voluntary sterilization procedure.
41. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us; all defibrillators other than implantable defibrillators Authorized by Us.
42. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.

43. Services or supplies for the prophylactic storage of cord blood.
44. Sleep studies, unless obtained in a facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 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.

ARTICLE V
ELIGIBLE MEDICAL EXPENSES

- A. Covered expenses are Medically Necessary, Allowable Charge for those medical services eligible for full or partial reimbursement under the Plan. They include:
1. Inpatient Bed, Board and General Nursing Service
 - a. Hospital room and board and general nursing services.
 - b. In a Special Care Unit for a critically ill Member requiring an intensive level of care.
 - c. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital. A maximum number of days per Benefit Period may apply if shown in the Schedule of Benefits.
 2. Other Hospital Services
 - a. Use of operating room, delivery room, treatment room, recovery room, and emergency room.
 - b. Anesthesia materials.
 - c. Laboratory examinations.
 - d. Oxygen and its administration.
 - e. Medical and surgical supplies.
 - f. All drugs and medicines approved by the Food and Drug Administration or its successor; blood, blood plasma, blood derivatives, and blood processing.
 - g. Electrocardiograms.
 - h. X-ray, nuclear medicine, sonography, and computerized tomography in Plan-approved units.
 - i. Physical Therapy.
 - j. Administration of anesthesia by an employee of the Hospital.
 - k. Intravenous injections and solutions.
 - l. Transfusion fee and equipment.

- m. Electroencephalograms.
 - n. Electroshock therapy.
 - o. Traction.
 - p. Heart laboratory, cardiovascular laboratory, or vascular laboratory.
 - q. Chemotherapy and radioisotope therapy, including use of materials such as nitrogen mustard, radioactive gold or radioactive iodine.
 - r. Induced positive pressure breathing.
 - s. Radiation therapy and high intensity x-ray therapy, including electrically produced therapy as well as radioactive materials, such as cobalt.
 - t. Radium and radium implant.
 - u. Hemodialysis, to include only expenses related to laboratory tests and consumable and expendable supplies, such as, dialysis solution, tubing and drugs required during dialysis.
2. Blood, blood plasma, blood derivatives, and blood processing.
3. Prescription drugs and medicines approved by the Food and Drug Administration, or its successor, which require a prescription by a Physician for use outside the Hospital. (This provision of the Plan shall not apply if such prescription drugs are payable under any other provision of the Plan.)
4. Oral Surgery Benefits
- a. Expenses Due to Accidental Injury

Expenses in connection with dental work or oral surgery for the prompt repair of sound, natural teeth when required as the result of an accidental injury, which occurs while covered under this Plan.
 - b. Other Expenses

Coverage for dental expenses not the result of an accidental injury will be limited to expenses in connection with oral surgery for:

 - (1) Treatment of tumors or cysts;
 - (2) The excision of partially or completely unerupted, impacted teeth;
 - (3) Complete excision of the tooth root without extraction of the entire tooth (apicoectomy);
 - (4) Open or closed reduction of fracture or dislocation of the mandible; and other incision or excision procedures on the gums and tissue of the mouth when they are not performed in connection with the extraction of teeth or periodontal treatment or surgery.

5. Services of a Physician except for: routine physical examinations, services for the fitting or prescription of eyeglasses or hearing aids, medical screens and immunizations, services of a resident or intern and treatment of teeth (unless specifically listed as an Eligible Medical Expense elsewhere in this Plan).
6. Services of a Physician for in-Hospital care of newborns.
7. Physical Therapy by a registered physical therapist who is not related to the Covered Person by blood, marriage, or adoption.
8. Private Duty Nursing charges of a registered nurse (R.N.) or licensed practical nurse (L.P.N.), provided the R.N. or L.P.N. is not related to the Covered Person by blood, marriage, or adoption.

No services of a private duty nurse will be covered unless such services are not a duplicate of normal staff nurse services.

Further, such services must not be of a custodial or sitter nature and must be certified by the attending Physician as Medically Necessary.

If it appears that Private Duty Nursing services will exceed forty-eight (48) hours, the Employee must contact the Third Party Administrator to get determination of whether or not the excess services will be covered.

9. Durable Medical Equipment when required for treatment of an illness or injury when:

Certificate is submitted in writing to the Plan by the Physician as to the medical necessity for the equipment and the anticipated length of time the equipment will be required for therapeutic use. The plan will pay for either the rental or the purchase of the equipment not to exceed the cost of the equipment. The Plan will not replace equipment that has been lost or damaged due to neglect or use not recommended by the manufacturer. Periodic recertifications may be required by the plan to determine the continued medical necessity of the equipment.

10. Prosthetic appliances, such as a manufactured hip joint or the initial purchase of an artificial leg or arm, for treatment of conditions caused only by accidental injury or illness occurring on or after the effective date of this Plan including the purchase of an initial implanted lens, contact lens, or corrective lens when such is being used to replace the natural lens removed as a result of injury or disease. For the purposes of this Plan, hearing aids, contact lens and/or corrective lens, for any purpose other than those stated above, are excluded.

11. Ambulance Service Benefits

- a. Benefits will be available for Ambulance Services for local transportation (when Medically Necessary):

- (1) to or from the nearest Hospital that can provide services appropriate to the Member's condition for an illness or injury requiring Hospital care;

- (2) 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;

- (3) for the Temporarily Medically Disabled Mother of an ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.
- b. 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 Member is in a location that cannot be reached by a ground ambulance.
- c. In a non-Emergency situation, air Ambulance Service is not covered unless the Member requests and receives Authorization from Us prior to the service being rendered.
- d. Ambulance Service Benefits will be provided as follows:
 - (1) If the Member pays a periodic fee to an ambulance membership organization with which We do not have a Provider Agreement, Benefits for expenses that the Member incurs for Ambulance Services will be based on any obligation the Member must pay that is not covered by the fee. If there is in effect a Provider Agreement between Us and the ambulance organization, Benefits will be based on the Allowable Charge.
 - (2) No Benefits are available if transportation is provided for the Member's comfort or convenience or is not Medically Necessary.
- 12. Skilled nursing facility charges, up to the maximum number of days for any one period of confinement provided that:
 - a. Such confinement commences within fourteen (14) days after a Hospital confinement of at least three (3) days duration;
 - b. Such confinement is necessary for the care and treatment of the sickness or injury which was the cause of the disability immediately preceding Hospital confinement; and
 - c. During such confinement, the Covered Person is under the regular care of a legally qualified Physician or surgeon.
- 13. Admission to a hospice care facility, in lieu of a Hospital Admission. There is a lifetime limit of six (6) months for hospice care, and it must be approved by the Plan's Third Party Administrator prior to Admission to the facility.
- 14. Expenses of a licensed, board certified social worker (BCSW), or licensed professional counselor (LPC) when such expense is associated with treatment rendered which is deemed Medically Necessary by a Physician and such Physician has referred the Covered Person to the provider. Such referral must be in writing.
- 15. Mammogram or pap test rendered or prescribed by a Physician or other appropriate Health Care provider licensed in Louisiana and received in any licensed Hospital or any other licensed public or private facility or portion thereof, including, but not limited to, clinics and mobile screening units. These charges will be limited to:

- a. Allowable Charge;
 - b. One baseline mammogram for any woman thirty-five (35) to thirty-nine (39) years of age;
 - c. One mammogram every twenty-four (24) months for any woman forty (40) to forty-nine (49) years of age;
 - d. One mammogram every twelve (12) months for any woman age fifty (50) or older;
 - e. An annual pap test for cervical cancer including charges for the office visit.
16. Complete basic immunization series as defined by the state health officer and required for school entry for children up to age six (6) including charges for the office visit.
17. Digital rectal examination and prostate-specific antigen (PSA) test limited to one (1) per Benefit Period including charges for the office visit, is covered for Members, fifty (50) years of age or older, and as recommended by his Primary Care Physician if the Member is over forty (40) years of age.

A second visit shall be permitted if recommended by the Member's Primary Care Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits.

The Deductible and Coinsurance amounts apply.

18. Hemoccult (colon) test, limited to one (1) per Benefit Period including charges for the office visit.
19. Non-experimental human-to-human organ transplant procedures, including subsequent related treatments (i.e., anti-rejection drugs, etc.), subject to the maximum benefits specified in the Schedule of Benefits for all organ transplant procedures combined. All expenses incurred five (5) days prior to the date the transplant procedure is performed will accrue toward the organ transplant lifetime maximum.

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) Preferred Provider facility, unless otherwise approved by BCBSLA in writing.

Organ transplants include, but are not limited to, heart, heart-lung, heart valve, prosthetic by-pass or replacement vessels, liver, pancreas, tissue, cornea, artery or vein, kidney, bone marrow and mechanical device transplants. The transplant of any part of an organ is considered to be an organ transplant.

The medical expenses incurred in acquiring the organ(s) to be used in any and all covered transplants received by a Covered Person include charges for:

- a. Tests for cross match donor, suitability and other such screening tests related to the donation of the organ(s), whether used or not; and
- b. Hospital, surgical, storage and transportation costs incurred that are related to the donation of the organ(s), whether used or not.

When only the transplant recipient is a Covered Person, the benefits of this Plan will be provided for the donor to the extent that benefits to the donor are not provided under any other form of coverage. In no such case under this Plan will any payment of a “personal service” fee be made to any donor, but only the necessary Hospital and Physicians’ medical care and services expense with respect to the donation will be considered for benefits. Expenses of the donor will be limited to \$30,000.00 of the transplant benefit payable under this Plan on the recipient’s behalf.

When only the donor is a Covered Person, the donor will receive benefits for care and service necessary to the extent such benefits are not provided for the donor under any coverage available to the recipient for the organ or tissue transplant procedure. Benefits will not be provided to any recipient who is not a Covered Person.

When the transplant recipient and the donor are both Covered Persons, benefits will be provided for each in accordance with his respective eligible expense.

20. 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 on Accreditation of Healthcare Organizations (JCAHO) or the American Academy of Sleep Medicine (AASM).

ARTICLE VI MEDICAL DEDUCTIBLE

A. Individual Deductible

The Deductible for each Covered Person is five hundred dollars (\$500.00) each calendar year for active employees and one thousand dollars (\$1,000.00) each calendar year for retired employees without Medicare Part A and B. The Deductible is not applicable to services rendered as a result of an occupational accidental injury occurring on or after the effective date of coverage.

B. Maximum Family Deductible

If three (3) or more Covered Persons within a family unit have satisfied their respective Deductible requirement during the same calendar year, or if Covered Persons within a family unit have incurred covered expenses equal to three (3) times the individual Deductible within a calendar year, all Covered Persons in that family unit will be deemed to have satisfied their respective individual Deductible requirement for that calendar year.

C. Special Deductible Provision

For Covered Persons on the effective date of the Plan who were covered under the Employer’s group insurance plan in effect on the day immediately preceding the effective date of the Plan, expenses applied toward satisfaction of that plan’s deductible requirement will be allowed to apply this amount, in whole or in part, towards satisfying the Plan’s Deductible for the current benefit period. Proof, satisfactory to the Plan, of expenses allowed toward the prior plan’s deductible must be submitted to the Plan with the claim for such benefit.

**ARTICLE VII
ORAL SURGERY BENEFITS**

Coverage is provided only for the following services or procedures. The highest level of benefits are available when services are performed by a PPO Provider, or by a provider in the Blue Cross and Blue Shield of Louisiana Key Dental Network. Access the Key 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. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- B. Extraction of impacted teeth.
- 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.)
- D. Excision of exostoses or tori of the jaws and hard palate.
- E. Incision and drainage of abscess and treatment of cellulitis.
- F. Incision of accessory sinuses, salivary glands, and salivary ducts.
- G. Anesthesia for the above services or procedures when rendered by an oral surgeon.
- H. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia benefits are not available for treatment rendered for Temporomandibular Joint (TMJ) Disorders.
- J. 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 You are eligible for these benefits, please call Our Customer Service Unit at the phone number on Your ID card, and ask to speak to a Case Manager.

**ARTICLE VIII
ACCIDENTAL INJURY BENEFIT**

For the accidental injury of an Employee occurring while said Employee is performing the duties of his job, the Plan will pay, not subject to the Deductible, one hundred percent (100%) of the Allowable Charge of the Eligible Medical Expenses, subject to the limitations and exclusions of the Plan. No benefits will be paid for any services rendered after the date coverage ends.

**ARTICLE IX
SUMMARY OF MEDICAL BENEFITS**

Subject to the limitation and exclusions of the Plan, payment for Medically Necessary, Allowable Charge expenses incurred by a Covered Person will be made in accordance with the following schedule:

- A. Benefits Not Subject to the Deductible

The Plan will pay one hundred percent (100%) of the Allowable Charge for all Employee on-the-job Accidental Injuries.

B. Benefits Subject to the Deductible

For eligible expenses other than those listed above, the Plan will pay, after the Deductible amount has been satisfied:

1. For eligible Hospital room and board expenses, the Plan will pay:
 - a. Eighty percent (80%) for services provided by a Blue Cross and Blue Shield of Louisiana Preferred Care PPO provider if the Authorization/Continued Stay Review requirements have been met; however, the Authorization/Continued Stay Review requirement does not apply for Admissions due to an on-the-job accident or an on-the-job sickness, or
 - b. Sixty percent (60%) for services provided by any other provider if the Authorization/Continued Stay Review requirements have been met; however, the Authorization/Continued Stay Review requirement does not apply for admission due to an on-the-job accident or an on-the-job sickness.
 - c. Fifty percent (50%) if the Authorization/Continued Stay Review requirements have not been met. The fifty percent (50%) paid by the Covered Person will not apply to the out-of-pocket maximum.
2. One hundred percent (100%) of eligible expenses incurred for pre-Admission testing, when performed on an Outpatient basis, provided such testing is done within seven (7) days of a scheduled Hospital confinement at the same Hospital where such confinement is scheduled to occur.
3. Eighty percent (80%) of the Eligible Medical Expenses for Inpatient psychiatric services when provided by a Blue Cross and Blue Shield of Louisiana Preferred Care PPO provider, or sixty percent (60%) of the Eligible Medical Expenses for Inpatient psychiatric services when provided by any other provider, and fifty percent (50%) for Outpatient psychiatric services. The maximum number of Outpatient visits per calendar year is fifty-two (52). The percentage paid by the Covered Person for psychiatric services will not apply to the out-of-pocket maximum. The maximum payment per benefit period for each Covered Person for all Inpatient and Outpatient psychiatric services combined is ten thousand dollars (\$10,000.00).
4. Eighty percent (80%) of eligible expenses, other than room and board, for eligible services provided by a Blue Cross and Blue Shield of Louisiana Preferred Care PPO provider, or sixty percent (60%) for eligible services provided by any other provider incurred while Hospital confined and the pre-Authorization/Continued Stay Review requirements have been met.
5. Fifty percent (50%) of eligible expenses, other than room and board, incurred while Hospital confined if the pre-Authorization/Continued Stay Review requirements have not been met. The fifty percent (50%) paid by the Covered Person will not apply to the out-of-pocket maximum.
6. For all other Eligible Medical Expenses:
 - a. Eighty percent (80%) of the first fifteen thousand dollars (\$15,000.00) in excess of the Deductible per calendar year for services provided by a Blue Cross and Blue Shield of Louisiana Preferred Care PPO provider, or

- b. Sixty percent (60%) of the first twelve thousand, five hundred dollars (\$12,500.00) in excess of the Deductible per calendar year for services provided by any other provider; plus
- c. One hundred percent (100%) of the excess over fifteen thousand dollars (\$15,000.00) for Blue Cross and Blue Shield of Louisiana Preferred Care PPO providers, or one hundred percent (100%) of the excess over twelve thousand, five hundred dollars (\$12,500.00) for any other provider for the remainder of the calendar year up to the life time maximum of two million dollars (\$2,000,000.00).

NOTE: The Out-of-Pocket amount incurred for Participating Providers is eligible for satisfying the Out-of-Pocket amount for Other Providers. The Out-of-Pocket amount incurred for Other Providers is eligible for satisfying the Out-of-Pocket amount for Participating Providers.

C. Out-of-Pocket Maximum

When a Covered Person's twenty percent (20%) co-payment (after the Plan has paid eighty percent (80%)) during a calendar year equals three thousand dollars (\$3,000.00) for services provided by a Blue Cross and Blue Shield of Louisiana Preferred Provider, or forty percent (40%) co-payment (after the Plan has paid sixty percent (60%)) during a calendar year equals five thousand dollars (\$5,000.00) for services provided by any other provider, the Plan will pay one hundred percent (100%) for the remainder of the calendar year for eligible expenses normally payable at eighty percent (80%) or sixty percent (60%).

D. Special Coinsurance Provision

For Covered Persons on the effective date of the Plan, who were covered under the Employer's group insurance plan in effect on the day immediately preceding the effective date of this Plan, expenses applied toward satisfaction of that plan's out-of-pocket amount will be allowed to apply this amount, in whole or in part, towards satisfying this Plan's out-of-pocket for the current benefit period. Proof, satisfactory to the Plan, of expenses allowed toward the prior plan's out-of-pocket must be submitted to the Plan with the claim for such benefit.

E. Maximum Benefit

The maximum benefit payable by the Plan is:

1. Two million dollars (\$2,000,000.00) during the lifetime of a Covered Person who is a full-time Employee or Retiree, or the covered Dependent of a full-time Employee or Retiree.
2. Three hundred thousand dollars (\$300,000.00) lifetime maximum benefit for all organ transplant procedures combined. This maximum will accrue toward the overall Lifetime Maximum Benefit.

F. Case Management

Under certain circumstances, alternate methods of treatment or types of expenses not normally covered under this Plan may be the most appropriate treatment for a particular injury or sickness. The Plan Supervisor, upon direction of the Employer, may, under those circumstances, process such types of treatment and/or expense as though they were covered under the Plan. The alternative benefits shall be determined on a case-by-case basis, and the Employer's determination to provide the benefits in one instance shall not commit the Employer to provide the same or similar alternative benefits for the same

Covered Person or any other Covered Person, nor shall it be deemed to waive the responsibility of the Plan supervisor to strictly apply the express discretion, may exercise this right, provided the Covered Person and the Covered Person's practitioner concur. The Plan may exercise this right when it anticipates future expenditures for Eligible Expenses for a Covered Person and such expenditures may be diminished by providing alternative benefits.

Home Health Care

Home Health Care services provided to a Member on an Outpatient basis in lieu of an Inpatient Admission and approved by the Third Party Administrator's case management.

G. Medical Benefits for Part-time and Reserve/Auxiliary Deputies

The medical coverage is limited to Covered Medical Expenses incurred as a result of an accidental injury occurring while on duty. Covered Medical Expenses for this Plan are the same as those described for full-time Employees and Retirees. There is a maximum benefit of fifty thousand dollars (\$50,000.00) per accidental injury.

When an on-the-job injury occurs, the Employee must contact his particular Sheriff's Department and complete an accident report. Consideration cannot be given to such Employee's claim until the accident report is submitted to the Plan's Third Party Administrator.

ARTICLE X. DISEASE MANAGEMENT

Qualification

The Member may qualify for Disease Management programs, at Our discretion, based on various criteria, including a diagnosis of chronic illness, severity, and proposed or rendered treatment. The program seeks to identify candidates as early as possible. Self-management techniques are reinforced and a personal nurse is assigned. The Member, Physicians and caregivers may be included in all phases of the disease management program. The disease management nurse may also refer members to community resources for further support and management.

Disease Management Benefits

Blue Cross Blue Shield of Louisiana's Disease Management programs are committed to improving the quality of care for its Members as well as decreasing health care costs in populations with a chronic disease. The nurse works with Members to help them learn the self-care techniques they will need in order to manage their chronic disease, establish realistic goals for life style modification, and improve adherence to their Physician prescribed treatment plan. Blue Cross and Blue Shield of Louisiana is dedicated to supporting the Physician's efforts in improving the health status and well-being of the Member.

ARTICLE XI AUTHORIZATION/CONTINUED STAY REVIEW

It is the responsibility of the Covered Person to obtain Authorization prior to an Inpatient Hospital Admission for anything other than an emergency or maternity. If application for Authorization is not made, only fifty percent (50%) of the covered charges will be paid, subject to the Authorization/Continued Stay Review maximum penalty. The remaining fifty percent (50%) will not be considered toward meeting the out-of-pocket maximum, as stated in the Schedule of Benefits.

The fifty percent (50%) benefit payment percentage applicable if the Authorization/Continued Stay Review requirements are not met will apply only to the first two thousand dollars (\$2,000.00) of covered expenses. Covered expenses in excess of two thousand dollars (\$2,000.00) will be payable in the same manner as if the Authorization/Continued Stay Review requirements had been met.

If the Authorization is granted, it will be for a specified number of days and the Plan's payment will be the percentage shown in the Schedule of Benefits. If additional days are required, Authorization must again be obtained if benefits are to continue.

Although Authorization is not required prior to Admission for an emergency, the Third Party Administrator must be notified of the Admission within forty-eight (48) hours or as soon thereafter as is reasonably possible.

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.

Certain services and supplies, as shown in the Schedule of Benefits, require Authorization prior to the services being rendered. Authorization can be obtained from the Third Party Administrator by calling the telephone number shown in the Schedule of Benefits or the Employee's Identification (ID) Card.

Prior to the expiration of the initial Authorized days, a request for an extension must be made and Authorized. Failure to timely request an extension of the Authorization may result in no Benefits if the extension is later determined not to be Medically Necessary.

NOTE: Authorizations and approval for Continued Stay may be requested by calling 1-800-523 -6435.

ARTICLE XII COORDINATION OF BENEFITS

- A. All benefits provided under the medical program are subject to this provision. This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan, and under all other plans covering an individual, exceed the allowable expenses incurred during a claim determination period.
- B. The coordination of benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.
- C. Determination of Benefits
 1. One of the two or more plans involved is the primary plan and the other plans are secondary plans. The primary plan pays benefits first and without consideration of the other plans. The secondary plans then make up the difference up to the total allowable expenses.
 2. No plan will pay more than it would have paid without this special provision. If one plan has no coordination of benefits provision, it is automatically primary.
 3. The rules for establishing the order of benefit determinations are:

- a. A plan may be primary if it covers the individual as an Employee and secondary if it covers the individual as a Dependent.
 - b. When a Child is covered as a Dependent under two or more plans:
 - (1) The plan of the parent whose birth date (month and day, not year) occurs earlier in the calendar year pays its benefits before the other parent's plan, and
 - (2) If one of the plans does not contain the provisions stated in (a) above, the plan of the male parent will pay its benefits before the plan of the female parent.
 - (3) When the parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of the plan which covers the Child as a Dependent or the parent with custody of the Child will be determined before the benefits of the plan which covers the Child as a Dependent of the parent without custody.
 - (4) When the parents are divorced and the parent with custody of the Child has remarried, the benefits of the plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits or the plan covering the Child as a Dependent of the step-parent, and the benefits of the plan covering the Child as a Dependent of the step-parent will be determined before the benefits of the plan covering that Child as a Dependent of the parent without custody.
 - (5) Notwithstanding (a) and (b) above, if there is a court decree which would otherwise establish financial responsibility for the Health Care expenses incurred by the Child, the benefits of the plan covering the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan covering the Child as a Dependent Child.
 - c. When an individual is covered under two or more plans as an active and retired or laid-off Employee:
 - (1) The plan covering the individual as an active Employee (or Dependent of an active Employee) will be primary, and the plan covering the individual as a retired or laid-off Employee (or Dependent of a retired or laid-off Employee) will pay secondary benefits.
 - (2) If one of the plans does not contain the provision stated in (a) above, the primary plan will be the plan that has covered the individual for the longer period of time.
4. When the total amount of benefits otherwise payable under this Plan during any claim determination period is reduced in accordance with this provision, each benefit that would be payable in absence of this provision shall be reduced either proportionately or in such other equitable manner as the Third Party Administrator shall determine and such reduced amount shall be charged against any applicable benefit limit of this Plan.
5. "Other Plan" as used herein means the following plans providing benefits or services for or by reason of medical or dental care or treatment: (1) Group insurance or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis; or (2) Any coverage for students which is sponsored by, or provided through, a school or other educational institution.

6. "Claim Determination Period" as used herein means calendar year.
7. "Allowable Expenses" as used herein means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one (1) of the plans covering the person for whom claim is made.

ARTICLE XIII PRE-EXISTING CONDITIONS

An accident or sickness for which a Covered Person received treatment or services, or took prescribed drugs or medicines during the twelve (12) month period immediately preceding the date the Covered Person became covered under this Plan is considered a Pre-Existing Condition. No benefits are provided for a Pre-Existing Condition during the first twelve (12) months of coverage. Within the definition of a Pre-Existing Condition, pregnancy is not to be considered a Pre-Existing Condition.

This Plan has a portability feature which may waive the Pre-Existing Condition limitation for individuals who were covered under a prior plan. This feature is explained below:

A. Enrollment without evidence requirement

An individual (Employee or Dependent) enrolling within the eligibility period who was covered either under an ERISA Plan or Non-ERISA Plan within at least sixty-three (63) days prior to such person's effective date under this Plan (excluding the new plan's waiting period) will be subject to the following:

1. If the individual was subject to the prior carrier's Pre-Existing Condition limitation, credit will be given under this Plan for the time the individual had coverage under the prior plan. Once the individual has been subject to a total twelve (12) month Pre-Existing Condition limitation (including the time covered under the prior plan as well as this Plan), the Pre-Existing Condition limitation under this Plan will not apply.
2. If the individual has a Pre-Existing Condition but was continuously covered under the prior plan for twelve (12) months or more, the individual will not be subject to the Pre-Existing Condition limitation under this Plan, provided application is made within thirty (30) days of the date the individual becomes eligible.

B. Enrollment with evidence requirement

An individual who does not enroll within the eligibility period will be subject to this Plan's standard Pre-Existing Conditions limitation.

ARTICLE XIV CLAIMS

- A. Written notice of claim must be given to the Claims Administrator within thirty (30) days after the commencement of any claim covered by the Plan or as soon thereafter as is reasonably possible.
- B. Written proof of claim must be given to the Claims Administrator by the end of the calendar year following the year in which the expense was incurred. However, when an Employee's coverage terminates for any reason, written proof of claim must be given to the Plan Administrator within ninety (90) days of the date of termination of coverage, provided that the Plan remains in force.

- C. Failure to furnish notice or proof within the time provided shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice of proof and that such notice or proof was furnished as soon as was reasonably possible.
 - D. The Plan shall have the right (at its own expense) to require a claimant to undergo a physical examination, when and as often as may be reasonable.
 - E. Payment of benefits for medical/dental expenses will be made:
 - 1. Directly to the Hospitals for Hospital services provided in Hospitals;
 - 2. To the Covered Person, to the Physician, or to the licensed anesthetist for professional services, according to assignment on the claim form.
- No assignment of benefits other than those prescribed above will be binding.
- No assignment will be made to the provider of Health Care services who will not complete discharge of the obligation of the Claims Administrator.
- F. No legal action against the Plan for the recovery of any claim shall be commenced within sixty (60) days or after three years from the expiration of the time in which proof of claim is required.
 - G. In the event that the claim of any person to all or any part of any payment or benefit under this Plan shall be denied, the Plan shall provide upon request to the claimant, a written notice setting forth, in a manner calculated to be understood by the claimant:
 - 1. The specific reason or reasons for the denial;
 - 2. Specific references to the pertinent plan provisions on which the denial is based;
 - 3. A description of any additional material or information necessary for the claimant to perfect the claim and explanation as to why such material or information is necessary; and
 - 4. An explanation of the Plan's claim procedure.
 - H. The Covered Person shall have the sole right to select his own Physician, surgeon, and Hospital and Physician-patient relationship shall be maintained.

ARTICLE XV APPEAL OF DENIED CLAIMS

A. Review of Claims Denied in Whole or in Part

A Member has sixty (60) days, from the date of receipt of notification of the Third Party Administrator's action on his or her Claim, to request a review of any Benefits denied in whole or in part.

To request a review, the Member must write to Blue Cross and Blue Shield of Louisiana, Claims Review Department (Customer Service Center), Post Office Box 98029, Baton Rouge, LA 70898-9029, stating the issue to be reviewed and attaching pertinent medical records or other information that the Member offers

in support of his or her Claims. The Member may also request a description of any pertinent records that the Third Party Administrator relied on in making its original decision to deny the Claim in whole or in part.

A disposition of the Claim will not be deemed final until such time as a written decision is rendered. The decision will be rendered within sixty (60) days after the request for review is received, unless medical records are requested from a Provider. In such case the decision will be rendered no later than one hundred twenty (120) days after the request for review is received. The Third Party Administrator has full discretionary authority to determine eligibility for Benefits and/or to construe the terms of this Benefit Plan. The Member will receive a written decision stating the specific reasons for the final decision with specific references to pertinent Benefit Plan provisions.

Should the written response not be in the member's favor, the member may request to appear before the LSA Insurance Advisory Committee.

The LSA Insurance Advisory Committee meets 1:00 p.m. on the third Wednesday of each month at the LSA Headquarters in Baton Rouge. The member's request to appear before the Committee must be in writing and must be received no less than ten (10) days prior to the scheduled meeting.

Should the Committee hear the member's request, and subsequently deny the appeal, no further action will be taken unless the member can present additional information regarding the claim.

B. Time Limit for Legal Action

No legal action against the Plan for the recovery of any claim may be filed

1. earlier than sixty (60) days after the notice of claim has been given; or
2. later than three (3) years after the date services are rendered.

ARTICLE XVI AMENDMENTS

- A. The Administrator shall have the right from time to time to amend the Plan and Trust in a manner not inconsistent with the Plan provided that no change shall deprive any Covered Person of any vested interest hereunder (unless required in order to qualify under Section 401 (a) of the Internal Revenue Code) nor increase the duties of the Trustee except with its written consent. The Administrator shall make no change which would cause its plan to lose its qualified status under Section 401 of the Internal Revenue Code.
- B. No amendment or amendments to this Plan will cause any part of the Trust Fund to be used for, or diverted to, any purpose other than the exclusive benefit of Covered Persons, their eligible Dependents or beneficiaries; provided, however, that the Administrator may make any amendment it determines necessary or desirable, with or without retroactive effect, to comply with the Internal Revenue Code.
- C. Any action by the Administrator under this Plan may be by resolution of its Board of Directors, or by any person or persons duly authorized by resolution of said Board to take such action.

**ARTICLE XVII
RESERVATION OF RIGHTS BY THE EMPLOYER AND
LIMITATIONS OF RIGHTS OF PARTICIPANTS**

- A. Although it is the intention of the Employer that the Plan shall be continued and its contributions made regularly, the Plan is entirely voluntary on the part of the Employer and the continuance of the Plan and the payments thereunder are not assumed as a contractual obligation of the Employer.
- B. This Plan shall not be deemed to constitute a contract between the Employer and any Covered Person or to be a consideration or an inducement for the employment of any Covered Person or Employee. Nothing contained in this Plan shall be deemed to give any Covered Person or Employee the rights to be retained in the service of the Employer or to interfere with the right of the Employer to discharge the Covered Person or Employee at any time regardless of the effect which such discharge shall have upon him as a Covered Person of the Plan.
- C. It is intended that the Plan shall be approved and qualified by the Internal Revenue Service as meeting the requirements of the Federal Internal Revenue Code and Regulations issued thereunder with respect to the Employee's Plans and Trusts so that contributions so made and the income of the Trust Fund shall be exempt from federal income tax. In the event the Commissioner of Internal Revenue or his delegate rules that the Plan set forth in this Agreement is not qualified, or a deduction for all or a part of the Employer's contribution is not allowed, the Employer reserves the right to recover that portion or all of its contribution for which no income tax exemption is allowed.

**ARTICLE XVIII
TERMINATION OF PLAN**

- A. The Employer may terminate the Plan and the Trust at any time.
- B. In no event, shall the liability of the Employer to the Covered Person exceed the value of the assets in the Trust. It is not intended by the Trust to pledge or in any other way secure the liabilities of the Trust with the assets of the Employer or any Participating Employer.
- C. Upon the termination of the Plan, any and all monies remaining in the Trust after the payment of all claims and expenses shall be used for the continuance of one or more benefits of the type described in Section 501(c)(9) of the Internal Revenue Code of 1954, as amended, until such monies have been exhausted.

**ARTICLE XIX
SUBROGATION**

- A. To the extent that Benefits for Covered Services are provided or paid under the Plan, the Plan will be subrogated and will succeed to the Member's right for the recovery of the amount paid under the Plan against any person, organization or other carrier even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights. The Plan's right to subrogation comes first even if the Member is not paid for all of the Member's Claim for damages or even if the payment the Member receives is for, or is described as for, the Member's damages other than health care expenses, or if the Member recovering the money is a minor. All costs that the Member incurs (including attorney fees) in exercising any right of recovery will be the Member's responsibility. Amounts that We paid on behalf of the Plan for which a third party or insurer is responsible will not be reduced by the amount of the Member's costs. The Plan may recover

attorney fees in accordance with La. Revised Statute 33:1448.

- B. The Member will reimburse the Plan all amounts recovered by suit, settlement, or otherwise from any third party or the Member's insurer to the extent of the Benefits provided or paid under the Plan. The Plan's right to reimbursement comes first even if the Member is not paid for all of the Member's Claim for damages or even if the payment the Member receives is for, or is described as for, the Member's damages other than health care expenses, or if the Member recovering the money is a minor. All costs that the Member incurs (including attorney fees) in exercising any right of recovery will be the Member's responsibility. Amounts that We paid on behalf of the Plan for which a third party or insurer is responsible will not be reduced by the amount of the Member's costs. The Member shall hold in trust for the account of the Plan all amounts recovered, up to the total amount of Benefits paid. The Plan appoints the Member as its representative for such limited purpose only. The Plan may recover attorney fees in accordance with La. Revised Statute 33:1448.
- C. The Member will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of the Plan's rights, and will take no action prejudicing the Plan's rights and interest. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Plan.
- D. The Member will notify Us of any Accidental Injury.
- E. If any portion of the provision above is contrary to applicable law, the entire provision shall not be invalid but shall be considered to be modified to the minimum extent necessary to comply with law.

ARTICLE XX MEDICARE

If this Plan is primary, the same schedule of benefits that applies to all other Covered Persons will apply to Covered Persons eligible for Medicare.

If Medicare is primary, the Covered Person will need to file the claim with Medicare first. After the Medicare Explanation of Benefits is received, the Covered Person should then file with this Plan and attach the Medicare explanation of Benefits with the claim.

The benefit under this Plan will be the lesser of:

- A. The remainder of the bill after the Medicare payment (when a Physician accepts assignment of benefit, the remaining balance on the bill is calculated from the Medicare approved amount).
- B. The normal Plan benefits calculated without considering the Medicare payment.

The only exception to the above comparison is for prescription drugs and Private Duty Nursing. These claims will not have a Medicare payment, as Medicare does not cover these services. For Private Duty Nursing, the Deductible is waived and the normal coinsurance of this Plan is applied. For Prescription Drug Benefits see Article XIX.

**ARTICLE XXI
PRESCRIPTION DRUG BENEFIT**

- A. Benefits for Prescription Drugs are covered under a Prescription Drug card program. Under this program, the Member should have his/her prescriptions filled by a pharmacy participating in the Prescription Drug card program and should present his/her Prescription Drug card when paying for prescriptions. To obtain Benefits through a mail order service, the Member must complete a mail service pharmacy order form and follow the instructions contained on that form.

A calendar year Prescription Drug Deductible Amount per Member will apply prior to the application of co-payments. Please refer to your Schedule of Benefits for Prescription Drug Deductible Amount.

1. The Member is responsible for the applicable Prescription Drug Copayment and for any Prescription Drug Deductible Amount for each prescription. This Prescription Drug Deductible Amount does not accrue to the Benefit Period Deductible Amount.
2. If a Member uses a pharmacy, which does not participate in the Prescription Drug card program, a Prescription Drug claim form must be completed by the Member. The Member will be responsible for the Prescription Drug Copayment, any Prescription Drug Deductible Amount, and any amount remaining over the Allowable Charge.
3. **THE FOLLOWING CATEGORIES OF PRESCRIPTION DRUGS REQUIRE PRIOR AUTHORIZATION. IF THE PRESCRIPTION DRUG REQUIRES PRIOR AUTHORIZATION, YOUR PHYSICIAN MUST CALL 1-800-376-7741 TO OBTAIN THE AUTHORIZATION. CALL THE CUSTOMER SERVICE TELEPHONE NUMBER ON YOUR ID CARD TO SEE IF THE CATEGORIES OF PRESCRIPTION DRUGS REQUIRING PRIOR AUTHORIZATION HAVE CHANGED:**

Specialty Drugs/Biotechnology Medicines - Examples include, but are not limited to:

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

Controlled Dangerous Substances - Examples include, but are not limited to:

- **Schedule II Drugs***

*** Shall include all drugs that are in this category.**

NOTE: BENEFITS WILL NOT BE PAID FOR THESE PRESCRIPTION DRUGS UNLESS PRE-AUTHORIZATION IS OBTAINED.

B. Prescription Drug Copayments

Please refer to your Schedule of Benefits for Copayment amounts and dispensing limitations

C. Limitations and exclusions applicable to the Prescription Drug benefit

No benefits will be received for Prescription Drugs that are determined by the Plan not to be Medically Necessary for the treatment of illness or injury. The following Prescription Drugs are also excluded, regardless of any claim of Medical Necessity:

1. Prescription Drugs used for cosmetic purposes or weight reduction including Retin A and monoxidil, except for oral monoxidil when Medically Necessary and prescribed for a purpose other than cosmetic.
2. Any medication not proven effective in general medical practice.
3. Investigative drugs and drugs used other than for the FDA approved indication.
4. Fertility drugs.
5. Minerals and vitamins, except for vitamins requiring a prescription for dispensation.
6. Nutritional supplements.
7. Prescription Drugs for which pre-authorization has not been obtained, when required.
8. Contraceptive devices.
9. Prescription Drugs if an equivalent product is available over the counter.
10. Refills in excess of the number specified by the Provider or the dispensing limitation shown in the Schedule of Medical Benefits, or refills dispensed more than one year after the date of the Provider's original prescription.
11. Methadone.
12. Any drugs used for smoking cessation.
13. Medication prescribed for any treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies.

ARTICLE XXII

BLUECARD PROGRAM COVERED PERSON LIABILITY – MEMBER PROVISIONS

A. BlueCard Program Member Liability

When a Covered Person obtains health care services through BlueCard outside the geographic area the Third Party Administrator serves, the amount the Covered Person pays for Treatment is calculated on the **lower** of:

- The billed charges for the Covered Person's Treatment, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to

the Third Party Administrator.

Often, this “negotiated price” will consist of a simple discount, which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the Covered Person’s health care Provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with the Covered Person’s health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount **the Covered Person** pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating a Covered Person’s liability for Treatment that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Covered Person liability calculation methods that differ from the usual BlueCard method noted above in paragraph one (1) of this section or require a surcharge, the Third Party Administrator would then calculate the Covered Person’s liability for any covered health care services in accordance with the applicable state statute in effect at the time the Covered Person received care.

B. Non-Participating Provider Member Liability

When the Covered Person obtains health care services outside the geographic area the Third Party Administrator serves from a Non-participating Provider of the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) of that area, the amount the Covered Person pays for Covered Services will generally be based on either the Host Blue’s Non-participating Provider local payment amount/rate or the pricing arrangements required by applicable state law. Because the amount the Third Party Administrator generally pays for such Non-participating Providers’ claims is based on the Host Blue’s local payment amount/rate, the Covered Person may be liable for the difference between the amount that the Non-participating Provider bills and the amount the Third Party Administrator will pay for the Covered Service as set forth in this Benefit Plan.

ARTICLE XXIII GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

IN ADDITION TO THE GENERAL PROVISIONS FOR GROUP/POLICYHOLDER AND MEMEBERS, THE FOLLOWING GENERAL PROVISIONS WILL ALSO APPLY TO THE GROUP/POLICYHOLDER

BLUECARD PROGRAM COVERED PERSON LIABILITY

Like all Blue Cross and Blue Shield Licensees, Blue Cross and Blue Shield of Louisiana (Third Party Administrator) participates in a program called “BlueCard.” Whenever a Covered Person accesses health care services outside the geographic area the Third Party Administrator serves, the claim for those services may be processed through BlueCard and presented to the Third Party Administrator for payment in conformity with network access rules of the BlueCard Policies then in effect (“Policies”). Under BlueCard, when a Covered Person receives covered health care services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee (“Host Blue”), the Third Party Administrator will remain responsible to the Covered Person for fulfilling its contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its Participating Providers and handling all interaction with its Participating Providers. The financial terms of BlueCard are described generally below.

A. Liability Calculation Method Per Claim

The calculation of a Covered Person's liability on claims for covered health care services incurred outside the geographic area the Third Party Administrator serves and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price the Third Party Administrator pays the Host Blue.

The calculation of a Covered Person's liability on claims for covered health care services incurred outside the geographic area the Third Party Administrator serves and processed through BlueCard will be based on the negotiated price the Third Party Administrator pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by the Third Party Administrator on a claim for health care services processed through BlueCard may represent:

1. the actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"), or
2. an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or
3. an average price, determined by the Host Blue in accordance with BlueCard Policies, based on billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Covered Person and the Plan from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Covered Person and the Plan is the final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the Plan being held in a variance account by the Host Blue, pending settlement with its Participating Providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the Plan and are eventually exhausted by Provider settlements and through prospective adjustments to the negotiated prices.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating a Covered Person's liability for covered health care services that does not reflect the entire saving realized, or expected to be realized, on a particular claim, or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate a Covered Person's liability and the Plan's liability for any covered health care services consistent with the applicable state statute in effect at the time the Covered Person received those services.

B. Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from Participating Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third-party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

C. BlueCard Fees and Compensation

The Plan understands and agrees:

- (1) to pay certain fees and compensation to the Third Party Administrator which is obligated under BlueCard to pay to the Host Blue, the Blue Cross and Blue Shield Association, or to the BlueCard vendors, unless the Third Party Administrator's contract obligations to the Plan require those fees and compensation to be paid only by the Third Party Administrator; and
- (2) that fees and compensation under BlueCard may be revised from time to time without the Plan's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard.

Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Also, some of these claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to the Plan as an additional claim liability. Other fees, include, but are not limited to, an 800 number fee and a fee for providing PPO Provider directories. If you do not have a complete listing, or want an updated listing, of these types of fees or the amount of these fees paid directly to the Plan, the Plan should contact Blue Cross and Blue Shield of Louisiana.

U.S. ECONOMIC SANCTIONS LAWS COMPLIANCE

The Group hereby agrees to comply fully with all applicable economic sanctions and export control laws and regulations, including those regulations maintained by the U.S. Treasury Department's Office of Foreign Assets Control (OFAC). The Group understands that Blue Cross and Blue Shield of Louisiana does not authorize extending coverage to any person to whom the provision of such coverage would be receiving insurance coverage under this or other Blue Cross and Blue Shield of Louisiana Policies, including Employees and their covered Dependents, against all relevant U.S. Government lists of persons subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to provide coverage to any person. The Group agrees that its acceptance of coverage constitutes a representation to Blue Cross and Blue Shield of Louisiana that all applicable laws and regulations have been complied with and that coverage is not being provided to any denied person.

Any extension of coverage in breach of the foregoing shall constitute cause for immediate termination of this Benefit Plan, and denial of benefits for any claims made under that coverage, and shall entitle Blue Cross and Blue Shield of Louisiana to indemnification from the Group for any cost, loss, damage, liability, or expense incurred by Blue Cross and Blue Shield of Louisiana as a result thereof. This provision shall survive termination or cancellation of this Benefit Plan.