State of Louisiana
Office of Group Benefits

Your EPO Plan Benefit Summary

2009–2010

UnitedHealthcare®
Healing health care. Together.®

Exclusive Provider Organization Plan Document
2009–2010

Table of Contents

Article 5

Office of Group Benefits
(Herein called the Program)

Group Coverage:
Self-insured and self-funded comprehensive medical benefits plan
Plan Year: July 1 - June 30

Employer Information: Goverment agencies of the State of Louisiana
(herein called Participant Employers).

UnitedHealthcare is entitled to rely upon the signature of the designated representatives of each of the agencies whose employees are covered by this Program as acting for the agency as to any and all matters pertaining to this Program.

In consideration of the payment of appropriate contributions, UnitedHealthcare hereby agrees, subject to the terms appearing on this and the following pages of this Plan Document including, if any, the riders, endorsements, and amendments to this Program which have been or will be approved, to pay benefits in accordance with the terms of this Plan Document.

Exclusive Provider Organization (EPO) Plan Document – July 2009

Active Employees and Retirees without Medicare

COVERED BENEFIT: IN NETWORK	EPO Plan (Administered by UnitedHealthcare) Nationwide
Lifetime Maximum Benefit (in- and out-of-network)	$5 million per person (includes medical and prescription drugs)
Plan Year Deductible Employees and dependents	$300/active & retired; non-Co-pay services Family Unit Maximum: 3 individual deductibles
Maximum Out-Pocket Expense in Network	N/A
Hospital Services (inpatient)	$100 per day[2] Max of $300 per admission
Surgeon, Anesthesia, Lab, & X-rays	Plan Covers at 100%[1]
Hospital Emergency Room (facility only)	$100 Co-pay/waived if admitted (Hospital Co-pay applies)[2]
Ambulatory Surgical Facilities	$100 Co-pay
Physician Visits	$15 PCP/$25 Specialist (no referral required)
Maternity (physician only)	$90 Co-pay
MRI/Cat Scan	$50 Co-pay
Sonograms	$25 Co-pay
Chemical/Radiation Therapy	Plan covers at 100%[1]
Dialysis[2]	Plan covers at 100%[1]
Pre-admission Testing	Plan covers at 100%[1]
Cardiac Rehabilitation Therapy	$15 Co-pay (within 6 months)
Physical and Occupational Therapy	$15 Co-pay
Speech Therapy[2]	$15 Co-pay
Oral Surgery (impacted tooth removal only)	100% of reasonable and customary
Routine PAP Test	Plan covers at 100%; one every 12 months
Routine Mammogram	Plan covers at 100%[3]
Routine PSA Screening	Plan covers at 100%[3]; one every 12 months
Ambulance (transportation only) ground Licensed Air Ambulance	 $50 co-payment $250 co-payment
Durable Medical Equipment	Plan covers 80% of Contracted Rate[1]
Home Health Care[2]	Case Management Required $15 Co-pay
Hospice Care[2]	Case Management Required Plan pays 80% of negotiated rate[2]
Wellness Program Baby/Child Routine exams, scheduled immunizations Adult Physical exam, lab, x-ray Eye Exam/Annual	 $15 Co-pay for PCP Visits[1] 100% of eligible expenses to $200[3] N/A
Prescription Drug Benefit In Network	Member pays 50%; max. $50 per 30-day fill After $1200 per person per plan year Co-pay Brand - $15, Generic -$0
Mail Order Drug Program	same as above
Mental Health & Substance Abuse/Inpatient[2] Max. 45 inpatient days person/plan year	Plan covers at 80% Separate $200 deductible (in & out patient) Inpatient-$50 per day-Max. 5 days
Mental Health & Substance Abuse/Outpatient[2] Max. 52 visits/year	Plan covers at 80%
COVERED BENEFIT: OUT-OF-NETWORK	
Member resides in Louisiana Plan	Separate $300 deductible, Out of Pocket Maximum - $3,000 per member /$9,000 per family Plan covers 70% reasonable and customary[1]
Member resides outside of Louisiana Plan	Separate $300 deductible Out of Pocket Maximum - $3,000 per member /$9,000 per family Plan covers 70%reasonable and customary[1]

1 Subject to plan year deductible and/or applicable co-insurance
2 Pre-authorization required
3 Age and/or time restrictions apply

Retirees with Medicare

Type of Benefit	Network Benefis/Copayment
Lifetime Maximum (in- and out-of-network)	$5 Million per person
Plan Year Deductible Employees and dependents	$300 Retired Family Unit Maximum: 3 individual deductibles
Maximum Out-of-Pocket Expense in Network	$2,000 per person
Hospital Services (Inpatient)	Plan covers up to 80% of MC Inpatient ded[1]
Surgeon, Anesthesia, and X-Rays	Plan covers up to 100% of MC Co-ins/ded[1]
Hospital Emergency Room (facility only)	$100 Copay/Waived if admitted Plan covers up to 80% of MC Co-ins/ded[1]
Ambulatory Surgical Facilities	Plan covers 80% of MC Co-ins/ded[1]
Physicians Visits	Plan covers 80% of MC Co-ins/ded[1]
MRI/Cat Scan	Plan covers 80% of MC Co-ins/ded[1]
Sonograms	Plan covers 80% of MC Co-ins/ded[1]
Chemical/Radiation Therapy	Plan covers 80% of MC Co-ins/ded[1]
Pre-Admission Testing & Dialysis	Plan covers 80% of MC Co-ins/ded[1]
Cardiac Rehabilitation Therapy	Plan covers 80% of MC Co-ins/ded[1]
Physical and Occupational Therapy	Plan covers 80% of MC Co-ins/ded[1]
Speech Therapy[2]	Plan covers 80% of MC Co-ins/ded[1]
Oral Surgery (impacted tooth removal only)	Plan covers up to 100% of MC Co-ins/ded[1]
Routine PAP Test	Plan covers 80% of MC Co-ins/ded[1]
Routine Mammogram	Plan covers 80% of MC Co-ins/ded
Routine PSA Screening	Plan covers 80% of MC Co-ins/ded
Ambulance (transporting only)	
Ground	Plan covers 80% of MC Co-ins/ded[1] after $50 Copayment
Licensed Air Ambulance	Plan covers 80% of MC Co-ins/ded[1] after $250 copayment
Durable Medical Equipment	Plan covers 80% of MC Co-ins/ded[1]
Home Health Care	Non-covered benefit when MC is primary
Hospice Care	Non-covered benefit when MC is primary
Wellness Program Adult Physical exam, lab, x-ray	 80% of Fee Schedule up to $200 Age and/or time restrictions apply
Prescription Drug Benefit In Network	Member pays 50%; max $50 per 30-day fill After $1,200 per person per plan year Co-pay Brand - $15, Co-pay Generic $0
Mail Order Drug Program	Same As Above
Mental Health & Substance Abuse/Inpatient[2] Max. 45 inpatient days person/plan year	Plan covers at 80% Separate $200 deductible (in & out patient) Inpatient - $50 per day – max 5 days
Mental Health & Substance Abuse/Outpatient[2] Max. 52 visits/year	Plan covers at 80%

1 Subject to plan year deductible and/or applicable co-insurance
2 Complete within 6 months
3 Medical Supplies are subject to deductibles and co-insurances
Retirees with Medicare
This is a summary of Plan features; however, for full details of the plan refer to the official Plan Document.

Summary of Exceptions and Exclusions*

Procedures and services that are NOT covered under this Plan, include, but are not limited to:

Abortion (elective, nontherapeutic)

Administrative fees, interest, penalties, or sales tax

Artificial organ implants, penile implants, transplantation of other than Homo sapiens (human) organs and any surgery and other treatment, services or supplies, related to such procedures, or to complications related to such procedures

Charges for services rendered over the telephone from a Physician to a Covered Person

Charges in excess of the UnitedHealthcare contracted amount for services, supplies, and treatment

Convalescent, skilled nursing, sanitarium, custodial or rest care

Cosmetic surgery (unless necessary for the immediate repair of a nonoccupational disease, accident or injury and then only on the specific part of the body directly affected)

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

Footcare: Expenses incurred for shoes and related items similar to wedges, cookies and arch supports

Genetic testing, except when determined to be Medically Necessary

Hair plugs and/or transplants

Hearing aids (including examination to determine necessity or fitting) Limited Benefits provided for Hearing aids for covered dependents under age 18. See plan document for full details

Injuries sustained while in an aggressor role. Expenses incurred as a result of a covered persons commission or attempted commission of an illegal act

Marriage counseling and/or family relations counseling, divorce counseling, parental counseling, job counseling and career counseling

Maternity expenses incurred by any person other than the Employee or the Employee's legal spouse

Personal convenience items, including admission and bedside kits, telephone, guest meals and beds, etc.

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

Routine physical examinations or immunizations not listed under Eligible Expenses

Services and supplies in connection with or related to gender dysphoria

Services and supplies related to obesity, surgery for excess fat in any area of the body, resection of excess skin or fat following weight loss or pregnancy

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

Services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, Pain Rehabilitation Control and/or Therapy, and dietary or educational instruction for all illnesses, other than diabetes

Sleep disorder testing unless performed at a facility accredited by the American Academy of Sleep Medicine. No benefits are provided for sleep studies conducted in a patient's home, nor for surgical treatment of sleep disorders, except following demonstrated failure of non-surgical treatment and only upon specific case-by-case approval by the Plan. Sleep studies conducted at sleep centers located within health care facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations are covered.

Speech therapy (except when prescribed to restore loss of speech resulting from accidental injuries or structural or neurologic disease)

Treatment for Temporomandibular Joint Dysfunction (TMJ), except as listed in the Plan Document under Eligible Expenses

Treatment or services for mental health and substance abuse outside the treatment plan developed by the Office of Group Benefits' managed care contractor or by therapists with whom or at facilities with which the Program's managed care contractor does not have a contract

Transportation of surgeons or family members in connection with organ transplants

Treatment, services or medication prescribed without charge or obligation to pay

Vitamins and minerals, appetite suppressants, dietary supplements, nutritional or parenteral therapy, topical Minoxidil, Retin-A (past age 26), amphetamines (other than for Attention Deficit Disorder or Narcolepsy), nicotine gum, patches, or other products, services, or programs intended to reduce or cease smoking or other tobacco use, Seristun (other than for AIDS wasting), or over-the-counter drugs

Worker's Compensation (any expenses covered by a worker's compensation program)

For Medicare Primary Retirees

As a retiree covered by Medicare, you have several Medicare options available: Medicare Part A, Medicare Part B or Medicare Part D.

Medicare — Parts A and B

Benefits Payable:

A and B Portion:	80/20% of eligible expenses (after $300 deductible)*
Prescription Drugs:	50/50 copay, maximum to plan per maximum 30-day supply.

Medicare — Part A

Benefits Payable:

A-Portion:	80/20% of eligible expenses
B-Portion:	Same as Active employee
Prescription Drugs:	50/50 copay, maximum to plan per maximum 30-day supply.

Medicare — Part B

Benefits Payable:

A and B Portion:	80/20% of eligible expenses
Prescription Drugs:	50/50 copay, maximum to plan per maximum 30-day supply.

Medicare — Part D

The Office of Group Benefits will continue to offer its prescription drug program to its retirees.

* Plan year deductible – $300 per person

Article 1 – Eligibility

I. Persons to be Covered

Eligibility requirements apply to all participants in UnitedHealthcare's EPO Plan.

A. Employee Coverage

1. Employee – See Glossary.

2. Husband and wife, both Employees

No one may be enrolled simultaneously as an Employee and as a Dependent under the Plan, nor may a Dependent be covered by more than one Employee. If a covered spouse chooses at a later date to be covered separately, and is eligible for coverage as an Employee, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase the benefits.

3. Effective dates of coverage, New Employee, Transferring Employee
Coverage for each Employee who completes the applicable Enrollment Form and agrees to make the required payroll contributions to his Participant Employer is to be effective as follows:

   a. If employment begins on the first day of the month, coverage is effective the first day of the following month;

   b. If employment begins on the second day of the month or after, coverage is effective the first day of the second month following employment;

   c. Employee Coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. An Employee who completes an Enrollment Form after 30 days following the date of employment will be considered an overdue applicant.

   d. An Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer in order to maintain coverage without interruption. An Employee who completes a Transfer Form after 30 days following the date of transfer will be considered an overdue applicant.

4. Re-enrollment, Previous Employment

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

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

5. Members of Boards and Commissions
Except as otherwise provided by law, members of boards or commissions are not eligible for participation in the Plan. This section does not apply to members of school boards or members of state boards or commissions who are defined by the Participant Employer as full time Employees.

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

7. Pre-existing condition (PEC) – new employees

   a. The terms of the following paragraph apply to all eligible employees whose employment with a participating employer commences on or after July 1, 2001, and to dependents of such employees.

   b. UnitedHealthcare may require that such applicants complete a "Statement of Physical Condition" form and an "Acknowledgment of Pre-existing Condition" form.

   c. Medical expenses incurred during the first 12 months following enrollment of the employee and/or dependent will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately prior to the enrollment date of coverage. The provisions of this section do not apply to pregnancy.

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

B. Retiree Coverage

1. Eligibility

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

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

   c. **RETIREES WILL NOT BE ELIGIBLE FOR COVERAGE AS OVERDUE APPLICANTS.**

2. Effective Date of Coverage

   a. Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions.

   b. The Retiree is responsible for notifying his initial Participant Employer of re-employment and return to Retiree status.

C. Documented Dependent Coverage

1. Eligibility
   A Documented Dependent of an eligible Employee or Retiree will be eligible for Dependent Coverage on the latest of the following dates:

   a. The date the Employee becomes eligible;

   b. The date the Retiree becomes eligible;

   c. The date the covered Employee or covered Retiree acquires a Dependent.

2. Effective Dates of Coverage

   a. Documented Dependents of Employees
      Coverage for Documented Dependents will be effective on the date the Employee becomes eligible for Dependent coverage.

   b. Documented Dependents of Retirees
      Coverage for Documented Dependents of Retirees will be effective on the first day of the month following the date of retirement if the Employee and his Dependents were covered immediately prior to retirement. Coverage for Dependents of Retirees first becoming eligible for Dependent Coverage following the date of retirement will be effective on the date of marriage for new spouses, the date of birth for newborn Children, or the Date Acquired for other classifications of Dependents, if application is made within 30 days of the date of eligibility.

D. Pre-Existing Condition (PEC) - Overdue Application

1. The terms of the following paragraphs apply to all eligible Employees who apply for coverage after 30 days from the date the Employee became eligible for coverage and to all eligible Dependents of Employees and Retirees for whom the application for coverage was not completed within 30 days from the Date Acquired.

   The effective date of coverage will be:

   a. The first day of the month following the date of receipt by the Office of Group Benefits of all required forms prior to the fifteenth of the month;

   b. The first day of the second month following the date of the receipt by the Office of Group Benefits of all required forms on or after the fifteenth of the month.

2. The Office of Group Benefits will require that all overdue applicants complete a “Statement of Physical Condition” and an “Acknowledgement of Pre-existing Condition” form.

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

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

E. Special Enrollments - HIPAA

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

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

   a. Loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the Plan participant; or

   b. Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer contributions were ceased for cause or for failure of the individual participant to make contributions; or

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

2. After Acquired Dependents

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

   a. A special enrollment application must be made within 30 days of the termination date of the prior coverage or the date the new Dependent is acquired. Persons eligible for special enrollment for which an application is made more than 30 days after eligibility will be considered overdue applicants subject to a pre-existing condition limitation.

   b. The effective date of coverage shall be:

      i. For loss of other coverage or marriage, the first day of the month following the date of receipt by the Office of Group Benefits of all required forms for enrollment;

      ii. For birth of a dependent, the date of birth;

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

c. Special enrollment applicants must complete "Acknowledgment of Pre-existing Condition" and "Statement of Physical Condition" forms.

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

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

F. Retirees Special Enrollment

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

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

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

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

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

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

G. **Tricare for Life Option for Military Retirees**

Retirees eligible to participate in the Tricare for Life (TFL) option on and after October 1, 2001 who cancels coverage with the Office of Group Benefits upon enrollment in TFL may re-enroll in the Program in the event that the TFL option is discontinued or its benefits significantly reduced.

H. **Medicare+Choice/Medicare Advantage Option for Retirees**

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

1. During the month of November, for coverage effective January 1, or

2. During the next annual enrollment, for coverage effective at the beginning of the next Plan Year.

II. CONTINUED COVERAGE

A. Leave of Absence

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

   a. A participating employee who is granted leave of absence without pay due to a service-related injury may continue coverage and the participating employer shall continue to pay its portion of health plan premiums for up to 12 months.

   b. A participating employee who suffers a service-related injury that meets the definition of a total and permanent disability under the worker's compensation laws of Louisiana may continue coverage and the participating employer shall continue to pay its portion of the premium until the employee becomes gainfully employed or is placed on state disability retirement.

   c. A participating employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (F.M.L.A.) may continue coverage during the time of such leave and the Participating Employer may continue to pay its portion of premiums.

2. Leave of Absence Without Pay; No Employer Contributions to Premiums

An employee granted leave of absence without pay for reasons other than those stated in Paragraph 1 above, may continue to participate in an Office of Group Benefits benefit plan for a period up to 12 months upon the employee's payment of the full premiums due.

The Office of Group Benefits must be notified by the Employee and the Participant Employer within 30 days of the effective date of the Leave of Absence.

B. Disability

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

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

C. Surviving Dependents/Spouse

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

   a. The surviving legal spouse of an Employee or Retiree may continue coverage until the surviving spouse becomes eligible for coverage in a Group Health Plan other than Medicare;

   b. The surviving never married Children of an Employee or Retiree may continue coverage until they are eligible for coverage under a Group Health Plan other than Medicare, or until attainment of the termination age for Children, whichever occurs first;

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

d. Coverage provided by the Civilian Health and Medical Program of the Uniform Services (Campus Tricare)or Successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a Dependent Child.

2. A surviving spouse or Dependent cannot add new Dependents to continued coverage other than a child of the deceased Employee born after the Employee's death.

3. Participant Employer/Dependent Responsibilities:

a. It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Office of Group Benefits within 60 days of the death of the Employee or Retiree;

b. The Office of Group Benefits will notify the surviving Dependents of their right to continue coverage;

c. Application for continued coverage must be made in writing to the Office of Group Benefits within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated;

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

i. Failure to pay the applicable premium timley;
ii. Death of the surviving spouse;
iii. Eligibility of the survivingDependent Childunder a Group Health Plan other than Medicare.

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

i. Failure to pay the applicable premium timley;
ii. Eligibility of the survivingDependent Childunder a Group Health Plan other than Medicare.
iii. The attainment of the termination age for Children.

The provisions of paragraphs 1 through 3 of this subsection are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree, Continued coverage for surviving Dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

D. Over-Age Dependents

If a never married Dependent Child is incapable of self-sustaining employment by reason of mental retardation or physical incapacity, became incapable prior to attainment of age 21, and is dependent upon the covered Employee for support, the coverage for the Dependent Child may be continued for the duration of incapacity.

1. Prior to Dependent Child's attainment of age 21, an application for continued coverage must be submitted to the Office of Group Benefits together with current medical information from the Dependent Child's attending physician to establish eligibility for continued coverage as set forth above.

2 The Office of Group Benefits may require additional medical documentation regarding the Dependent Child's mental retardation or physical incapacity upon receipt of the application for continued coverage and as often as it may deem necessary thereafter..

3. For purposes of this section, mental illness as identifiedwith a DSM IV diagnosis code, does not constitute mental retardation.

E. Military Leave

Members of the National Guard or of the United States military reserves who are called to active duty, and who are Office of Group Benefits participating Employees or covered Dependents will have access to continued coverage under Office of Group Benefit's health and life plans.

1. Health Plan participation, when called to active military duty, participating employees and covered dependents may:

   a. Continue participation in the Office of Group Benefits health plan during the period of active military service, in which case the participating employer may continue to pay its portion of the premiums; or

   b. Cancel participation in the Office of Group Benefits health plan during the period of active military service, in which case such plan participants may apply for reinstatement of Office of Group Benefits coverage within 30 days of:

      i. The date of the Employee's reemployment with a participating Employer,

      ii. The Dependent's date of discharge from active military duty, or

      iii. The date of termination of extended health coverage provided as a benefit to active military duty, such as TRICARE Reserve Select;

      iv. Plan participants who elect this option and timely apply for reinstatement of Office of Group Benefits coverage will not be subject to a pre-existing condition (PEC) limitation, and the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 43:851E and the corresponding Rules promulgated by Office of Group Benefits.

F. Family and Medical Leave Act (F.M.L.A.) Leave of Absence.

An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave without pay. The participant employer shall pay the employee's share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employee.

III. COBRA

A. Employees

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

2. It is the responsibility of the Participant Employer to notify the Office of Group Benefits within 30 days of the date coverage would have terminated because of any of the foregoing events, and the Office of Group Benefits will notify the Employee within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Office of Group Benefits within 60 days of the date of notification and premium payment must be made within 45 days of the date the Employee elects continued coverage, for coverage retroactive to the date coverage would have otherwise terminated. Coverage under this section will continue until the earliest of the following:

   a. Failure to pay the applicable premium timely;
   b. 18 months from the date coverage would have terminated;
   c. Entitlement to Medicare;
   d. Coverage under a Group Health Plan, except when subject to a pre-existing condition limitation.
   e. The Employer ceases to provide any Group Health Plan for its employees.

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

B. Surviving Dependents

1. Benefits for covered surviving Dependents of an Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at his/her own expense.

2. It is the responsibility of the Participant Employer or surviving covered Dependents to notify the Office of Group Benefits within 30 days of the death of the Employee or Retiree. The Office of Group Benefits will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of the date of notification.

3. Premium payment must be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

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

i. Failure to pay the applicable premium timely; 36 months from the date coverage would have otherwise terminated;
ii. Death of the surviving spouse
iii. Entitlement to Medicare
iv. Coverage under a Group Health Plan, except when subject to a pre-existing condition limitation
v. The employer ceases to provide any Group Health Plan for its employees.

C. Divorced Spouse

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

2. It is the responsibility of the divorced spouse to notify the Office of Group Benefits within 60 days from the date of divorce and the Office of Group Benefits will notify the divorced spouse within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Office of Group Benefits within 60 days of notification.

3. Premium payment must be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have terminated.

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

a. Failure to pay the applicable premium;
b. 36 months beyond the date coverage would have terminated;
c. Entitlement to Medicare;
d. Coverage under a Group Health Plan, except when subject to a pre-existing condition.
e. The er ceases to provide any group Group Health Plan for its ess.

D. Dependent Children

1. Benefits under this Plan for a covered Dependent Child of a covered Employee or Retiree will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent elects to continue coverage at his or her own expense.

2. It is the responsibility of the Dependent to notify the Office of Group Benefits within 60 days of the date coverage would have terminated and the Office of Group Benefits will notify the Dependent within 14 days of his or her right to continue coverage..Application for continued coverage must be made in writing to the Office of Group Benefits within 60 days of receipt of notification and premium payment must be made within 45 days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have terminated.

3. Premium payment must be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have terminated.

4. Coverage for Children under this section will continue until the earliest of the following:

   a. Failure to pay the applicable premium;
   b. 36 months beyond the date coverage would have terminated;
   c. Entitlement to Medicare;
   d. Coverage under a Group Health Plan, except when subject to a pre-existing condition.
   e. The er ceases to provide any group Group Health Plan for its ess.

E. Dependents of COBRA Participants

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

1. Death of the Employee;
2. Divorce from the Employee; or
3. A Dependent Child no longer meets the definition of an eligible covered Dependent;

Then, the spouse and/or Dependent Child may elect to continue coverage at his/her own expense. Coverage will not be continued beyond 36 months from the date coverage would have terminated.

F. Dependents of Non-Participating Terminated Employee

1. If an Employee no longer meets the definition of an Employee, or a Leave of Absence has expired and the Employee has not elected to continue coverage, the covered spouse and/or covered Dependent Children may elect to continue coverage at his/her/their own expense. The elected coverage will be subject to the notification and termination provisions.

2. In the event a Dependent Child, covered under the provisions of the preceding paragraph no longer meets the definition of an eligible covered Dependent, he or she may elect to continue coverage at his or her own expense. Coverage cannot be continued beyond 36 months from the date coverage would have terminated.

G. Miscellaneous Provisions

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

H. Disability COBRA

1. If a Covered Employee or Covered Dependent is determined by Social Security or by the Office of Group Benefits staff (in the case of a person who is ineligible for Social Security Disability due to insufficient “quarters” of employment), to have been totally disabled on the date the Covered Person became eligible for continued coverage or within the initial 18 months of coverage, coverage under this Plan for the Covered Person who is totally disabled may be extended at his or her own expense up to a maximum of 29 months from the date coverage would have terminated.

To qualify the Covered Person must:

a. Submit a copy of his or her Social Security Disability determination to the Office of Group Benefits before the initial 18-month continued coverage period expires and within 60 days after the date of issuance of the Social Security determination; or

b. Submit proof of total Disability to the Office of Group Benefits before the initial 18-month continuation of coverage period expires.

2. For purposes of eligibility for continued coverage under this section, total Disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of 12 months. To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

3. The staff and medical director of the Office of Group Benefits will make this determination of total Disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.

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

a. 30 days after the month in which Social Security determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Office of Group Benefits within 30 days after the date of issuance by Social Security);

b. 29 months from the date coverage would have terminated;

I. Medicare COBRA

1. If an Employee becomes entitled to Medicare on or before the date the Employee's eligibility for benefits under this Plan terminates, the period of continued coverage available for the Employee's covered Dependents will be the earliest of the following:

a. Failure to pay the applicable premium
b. 36 months beyond the date coverage would have terminated
c. Entitlement to Medicare
d. Coverage under a Group Health Plan, except when subject to a pre-existing condition
e. The er ceases to provide any group Group Health Plan for its ess.

2. Premium payment must be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

IV. CHANGE OF CLASSIFICATION

A. Adding or Deleting Dependents

The Plan Member must notify the Office of Group Benefits whenever a Dependent is added to or deleted from the Plan Member's coverage and that action results in a change in the class of coverage. Applications for change must be made within 30 days of the event.

B. Change in Coverage

1. When, by reason of a change in family status (e.g., marriage, birth of child), the class of coverage is subject to change, the change in classification will be effective on the date of the event, if application for the change is made within 30 days of the date of the event.

2. When the addition of Dependent results in the class of coverage being changed, the additional premium will be charged for the entire month if the date of change occurs on or before the fourteenth day of the month. If the date of change occurs on or after the fifteenth day of the month, additional premium will not be charged until the first day of the following month

C. Notification of Change

It is the responsibility of the Employee to notify the Office of Group Benefits of any change in classification of coverage affecting the Employee's contribution amount. Any such failure later determined will be corrected on the first day of the following month.

V. CONTRIBUTIONS

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

Article 2 – Termination of Coverage

I. Active Employee and Retired Employee Coverage

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

1. On the date the Office of Group Benefits terminates

2. On the date the group or agency employing the covered Employee terminates or withdraws from the Office of Group Benefits

3. On the contribution due date if the group or agency fails to pay the required contribution for the covered Employee

4. On the contribution due date if the Covered Person fails to make any contribution which is required for the continuation of his coverage

5. On the last day of the month of the covered Employee's death

6. On the last day of the month in which the covered Employee ceases to be eligible

II. Dependent Coverage Only

A. Subject to continuation of coverage and COBRA rules, Dependent coverage will terminate under this Plan on the earliest of the following dates:

1. On the last day of the month the Employee ceases to be covered

2. On the last day of the month in which the Dependent, as defined in this Plan, ceases to be an eligible Dependent of the covered Employee

3. For grandchildren for whom the employee does not have legal custody or has not adopted, on the date the child's parent ceases to be a covered dependent under this Plan or the grandchild no longer meets the definition of Children

4. Upon discontinuance of all Dependent coverage under this Plan

Article 3 – Medical Benefits

I. MEDICAL BENEFITS apply when eligible expenses are incurred by a Covered Person.

Eligible Expenses are the charges incurred for the following services, drugs, supplies, and devices, when performed, prescribed, or ordered by a Physician and Medically Necessary for the Treatment of a Covered Person. All charges are subject to the applicable deductibles, copayments, and/or coinsurance amounts (unless otherwise specifically provided), Fee Schedule limitations, Schedule of Benefits, exclusions, and other provisions of the plan. A charge is incurred on the date that the service, drug, supply, or device is performed or furnished.

A. Hospital Care. The medical services and supplies furnished by a hospital or ambulatory surgical center. Covered charges for room and board will be payable as shown in the Schedule of Benefits;

B. Covered Services of a Physician

C. Routine Nursing Services, i.e., "floor nursing" services provided by nurses employed by the hospital are considered as part of the room and board

D. Anesthesia and its administration when ordered by the operating Physician and administered by an appropriately licensed nurse, anesthesist or Physician in conjunction with a covered surgical service;

E. Laboratory examinations and diagnostic X-rays

F. Nuclear medicine and electroshock therapy

G. Blood and blood plasma, blood derivatives and blood processing, when not replaced

H. Surgical and medical supplies billed for treatment received in a hospital or ambulatory surgical center, and other covered provider's surgical and medical supplies as listed below

1. Catheters - External and Internal
2. Cervical Collar
3. Leg Bags for Urinal Drainage
4. Ostomy Supplies except for supplies for nutritional and/or internal feeding
5. Prosthetic Socks
6. Prosthetic Sheath
7. Sling (Arm or Wrist)
8. Suction Catheter for Oral Evacuation
9. Surgical Shoe (following foot surgery only)
10. Plaster Casts
11. Splints
12. Surgical Trays (for certain procedures)

I. Services of licensed speech therapist when prescribed by a physician and pre-approved through Outpatient Procedure Certification for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injuries, or other similar structural or neurological disease; limited to 26 visits per plan year.

J. Intravenous injections, solutions, and eligible related intravenous supplies.

K. Services rendered by a doctor of dental surgery (D.D.S.) or doctor of dental medicine (D.M.D.) for the treatment of accidental injuries to a Covered Person's sound natural teeth, if:

1. Coverage was in effect with respect to the individual at the time of the accident.

2. Treatment commences within 90 days from the date of the accident and is completed within two years from the date of the accident; and

3. Coverage remains continuously in effect with respect to the Covered Person during the course of the treatment; eligible expenses will be limited to the original estimated total cost of treatment as estimated at the time of initial treatment.

4. Eligible expenses may include dental braces and orthopedic appliances, upon review and approval by the Program's Dental Consultant, and only under the following circumstances:

   a. To return the alveolar alignment to its former state prior to a covered dental accident. The program will allow benefits for orthopedic correction to establish reasonable occlusal function;
   b. A covered surgery that requires the use of braces for stabilization;
   c. Severe skeletal deformity (i.e. cleft palate). The Plan will allow benefits for orthopedic correction to establish reasonable occlusal function.

   Accidental injury means 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, the act of chewing does not constitute an injury caused by external force.

L. Durable Medical Equipment [UnitedHealthcare will require written certification by the treating physician to substantiate the medical necessity for the equipment and the length of time that it will be used. The purchase of Durable Medical Equipment will be considered an eligible expense only upon showing that the rental cost would exceed the purchase price. Under no circumstances may the eligible expense for an item of Durable Medical Equipment exceed the purchase price of such item.]

M. Initial prosthetic appliances. Subsequent prosthetic appliances are eligible only when acceptable certification is furnished to UnitedHealthcare by the attending Physician;

N. Professional ambulance services (when medically necessary), subject to the following provisions:

1. Licensed professional ambulance service in a vehicle licensed for highway use to or from a hospital with facilities to treat an illness or injury. Medical services and supplies will be considered separately.

2. Licensed air ambulance service to a hospital with facilities to treat an illness or injury. Medical services and supplies will be considered separately.

0. One pair of eyeglass lenses or contact lenses required as a result of bilateral cataract surgery performed while coverage was in force. Expenses incurred for the eyeglass frames will be limited to a maximum benefit of $50.00.

P. The first two pairs of surgical pressure support hose. Additional surgical support hose may be considered an eligible expense at the rate of one pair per six-month period.

Q. The first two ortho-mammary surgical brassieres. Additional ortho-mammary surgical brassieres may be considered an eligible expense at the rate of one per six-month period; limited to one pair per plan year.

R. Orthopedic shoes prescribed by a Physician and completely custom built, limited to one pair per plan year

S. Acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered.

T. Eligible expenses associated with an organ transplant procedure including expenses for patient screening, organ procurement, transportation of the organ, transportation of the patient and/or donor, surgery for the patient and donor, and immunosuppressant drugs, if:

1. The transplantation must not be considered experimental or investigational by the American Medical Association.

2. The transplant surgery must be performed at a medical center which has an approved transplant program as determined by Medicare.

3. The Plan will not cover expenses for the transportation of surgeons or family members of either the patient or donor.

4. All benefits paid will be applied against the lifetime maximum benefit of the transplant recipient.

U. Services of a Physical Therapist and Occupational Therapist licensed by the state in which the services are rendered when:

1. Prescribed by a licensed Physician and rendered in an individual setting

2. Services require the skills of and are performed by a licensed physical therapist or licensed occupational therapist

3. Restorative potential exists

4. Meets the standards for medical practice

5. Reasonable and medically necessary for the treatment of the disease, illness, accident, injury, or post operative condition

6. Approved through Case Management when rendered in the home

7. Limited to 50 visits combined (combined physical therapy and occupational therapy) per plan year

V. Cardiac Rehabilitation when:

1. Rendered at a medical facility under the supervision of a licensed Physician

2. Rendered in connection with a myocardial infarction, angioplasty with or without stinting, or cardiac bypass surgery

3. Completed within 6 months following the qualifying event

   Note: Charges incurred for dietary instruction, educational services, behavior modification literature, health club membership, exercise equipment, preventive programs, and any other items excluded by the Plan are not covered.

W. Preventative care consisting of routine physical examinations, lab work and immunizations (including a yearly influenza vaccination) as follows:

1. Well-Baby Care expenses subject to the annual deductible and copayments:

   a. Newborn facility and professional charges

   b. Birth to age 1 – all office visits for scheduled immunizations

2. Well-Child Care expenses subject to the annual deductible and copayments:

   a. Age 1 until age 3: 3 office visits per year for scheduled immunizations

   b. Age 3 until age 16: 1 office visit per year for scheduled immunizations and screening

3. Well-Adult Care expenses not subject to the annual deductible, but limited to a maximum benefit of $200.00:

   a. Age 16 until age 40 - $200 during a 3-year period;
   b. Age 40 until age 50 - $200 during a 2-year period;
   c. Age 50 and over - $200 during a 1-year period;

Note: Benefits for well baby and well child care and routine physical examination for adults, including immunizations are based on the U.S. Preventive Services Task Force guidelines and recommendations of the National Immunization Program of the Centers for Disease Control and Prevention. All services are rendered on an outpatient basis to monitor health and to prevent illness.

X. Specialized age appropriate wellness care not subject to the annual deductible, as follows:

1. One Pap test for cervical cancer per plan year;

2. Mammographic examinations performed according to the following schedule:

   a. One mammogram during the five-year period a person is 35-39 years of age;

   b. One mammogram every two plan years for any person who is 40-49 years of age;

   c. One mammogram every 12 months for any person who is 50 years of age or older;

3. Testing for detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing, once every twelve months for men over the age of 50 years.

Y. Outpatient surgical facility fees as specified in the maximum payment schedule;

Z. Midwifery services performed by a certified midwife or a certified nurse midwife;

AA. Services rendered by the following, when billed by the supervising physician:

1. Perfusionists and Registered Nurse Assistants assisting in the operating room;

2. Physician's Assistants and Registered Nurse Practitioners;

BB. Splint therapy for the treatment of Temporomandibular Joint Dysfunction (TMJ), limited to a lifetime benefit of $600 for a splint and initial panorex x-ray only. Surgical treatment for TMJ will only be eligible following a demonstrated failure of splint therapy and upon approval by UnitedHealthcare;

CC. Oxygen and oxygen equipment;

DD. Outpatient self-management training and education, including medical nutrition therapy, for the treatment of diabetes, when these services are provided by a licensed health care professional with demonstrated expertise in diabetes care and treatment who has completed an educational program required by the appropriate licensing board in compliance with the National Standards for Diabetes Self-Management Education program as developed by the American Diabetes Association, and only as follows:

1. A one-time evaluation and training program for diabetes self management, conducted by the health care professional in compliance with National Standards for Diabetes Self Management Education Program as developed by the American Diabetes Association, upon certification by the health care professional that the Covered Person has successfully completed the program, such benefits not to exceed $500.

2. Additional diabetes self-management training required because of a significant change in the patient's symptoms or conditions, limited to benefits of $100 per year and $2,000 per lifetime;

3. Services must be rendered at a facility with a diabetes educational program recognized by the American Diabetes Association.

EE. Testing of sleep disorders only when the tests are performed at either:

(1) a facility accredited by The American Academy of Sleep Medicine or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or

(2) a sleep study facility located within a healthcare facility accredited by JCAHO. No benefits are payable for surgical treatment of sleep disorders (including LAUP) except following demonstrated failure of non-surgical treatment and upon approval by UnitedHealthcare;

FF. Mental health and/or substance abuse services only when obtained through the UnitedHealthcare's managed care contractor as shown in the Schedule of Benefits. These services must be identified by a DSM IV diagnosis code.

GG. Hearing aids for use by a covered dependent child under the age of eighteen, subject to the following limitations:

1. The hearing aids must be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a licensed doctor of medicine (M.D.) and an audiological evaluation medically appropriate to the age of the child; and

2. The maximum amount payable is $1,400 per hearing aid for each hearing-impaired ear every thirty-six months.

HH. Treatment provided in accordance with a clinical trial for cancer, including costs of investigational treatments and of associated protocol related to patient care if all of the following criteria are met:

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

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

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

   a. One of the United States National Institutes of Health

   b. A cooperative group funded by one of the United States National Institutes of Health

   c. FDA in the form of an investigational new drug application

   d. United State Department of Veterans Affairs

   e. United States Department of Defense

   f. A federally funded general clinical research center

   g. Coalition of National Cancer Cooperative Groups

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

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

6. There is no clearly superior, non-investigational approach;

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

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

II. Routine colorectal cancer screening, including fecal occult blood test, flexible sigmoidoscopy, colonoscopy or equivalent screening procedure, provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

II. Contracted Rates

Eligible Expenses:

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.

- When Covered Health are received from non-Network providers as a result of an Emergency or as otherwise arranged by the Claims Administrator, Eligible Expenses are the fee(s) that are negotiated with the non-Network provider.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from non-Network providers, the Claims Administrator calculates Eligible Expenses based on available data resources of competitive fees in that geographic area.

Eligible Expenses are determined solely in accordance with the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.

- As reported by generally recognized professionals or publications.

- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

III. Utilization Review – Pre-Admission Certification, Continued Stay Review

A. Pre-Admission Certification (PAC) and Continued Stay Review (CSR) establish the medical necessity and length of inpatient hospital confinement.

1. It is the Plan Member's responsibility to assure that PAC is obtained for non-EPO facilities.

2. It is the provider's responsibility to obtain PAC for EPO facilities. If the provider fails to do this, the Plan Member cannot be billed for any amount not covered by this Plan.

B. For a routine vaginal delivery, PAC is not required for a stay of 2 days or less. If the mother's stay exceeds or is expected to exceed 2 days, PAC is required within 24 hours after the delivery or the date, on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate precertification number must be obtained for the baby. In the case of a Caesarean Section, PAC is required if the mother's stay exceeds or is expected to exceed 4 days.

C. No benefits will be paid under the Plan:

1. Unless PAC is requested at least 72 hours prior to the planned date of admission
2. Unless PAC is requested within two business days following admission in the case of an emergency
3. For hospital charges incurred during any confinement for which PAC was requested, but which was not certified as Medically Necessary by the Program's utilization review contractor
4. For hospital charges incurred during any confinement for any days in excess of the number of days certified through PAC or CSR

D. Benefits otherwise payable for services at a non-EPO facility will be reduced by 25% on any confinement for which PAC was not obtained.

E. Members should call 1-866-336-9374 for Utilization Review and Pre-certification.

IV. Outpatient Procedure Certification (OPC)

A. OPC certifies that certain outpatient procedures and therapies are Medically Necessary. If OPC is not obtained when required, no benefits are payable under the plan.

1. It is the Plan Member's responsibility to assure that OPC is requested on services performed by non-EPO providers
2. On services performed by an EPO provider, it is the provider's responsibility to obtain OPC. The Plan Member cannot be billed if the provider fails to do so.

B. OPC is required on the following procedure:

1. Speech Therapy
2. Occupational Therapy when performed in a home setting
3. Hyperbaric Oxygen Chamber treatment

C. No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility and professional fee in connection with speech therapy:

1. Unless OPC is requested at least 72 hours prior to the planned date of procedure or therapy
2. For charges incurred on any listed procedure for which OPC was requested but not certified as Medically Necessary by the UnitedHealthcare's utilization review contractor

V. Case Management

A. Case Management (CM) is the managed care program available in cases of illness or injury where critical care is required and/or treatment of extended duration is anticipated.

B. Case Management may provide coverage for services that are not normally covered. To be eligible, the condition being treated must be a covered condition, and Case Management must be approved prior to the service being rendered.

C. These charges are subject to the deductible, co-insurance, Contracted Rates, and maximum benefit limitations.

D. The following criteria must be met:

1. UnitedHealthcare must be the primary carrier at the time Case Management is requested. Any Case Management plan will be contingent upon UnitedHealthcare remaining the primary carrier;

2. The patient must not be confined in any type of nursing home setting at the time Case Management is requested;

3. There must be a projected savings to the Office of Group Benefits through Case Management; or a projection that Case Management expenses will not exceed normal Plan benefits; and

   a. The proposed treatment plan will enhance the patient's quality of life;

   b. Benefits will be utilized at a slower rate through the alternative treatment plan;

E. Mental health and substance abuse treatments or conditions are not eligible for Case Management.

F. Benefits are considered payable only upon the recommendation of the UnitedHealthcare's contractor, with the approval of the attending physician, patient or his representative, and UnitedHealthcare or its representative.

Approval is contingent upon the professional opinion of UnitedHealthcare's medical director, consultant, or his designee as to the appropriateness of the recommended alternative care.

G. If a condition is likely to be lengthy or if care could be provided in a less costly setting, UnitedHealthcare's contractor may recommend an alternative plan of care to the physician and patient.

VI. Dental Surgical Benefits

A. When excision of one or more impacted teeth is performed by a doctor of dental surgery (D.D.S.) or doctor of dental medicine (D.M.D.) while coverage is in force, UnitedHealthcare will pay, subject to the annual deductible, the eligible expense actually incurred for the surgical procedure.

B. If A Covered Person requires dental treatment in a hospital setting that is otherwise an Eligible Expense, the Plan will provide benefits for the anesthesia rendered in the hospital and associated hospital charges.

a. Prior authorization for hospitalization for dental treatment is required in the same manner as prior authorization for other covered medical services.

b. The provisions of this section shall not apply to treatment rendered for Tempormandibular Joint (TMJ) diseases or disorders.

C. Eligible expenses incurred in connection with the removal of impacted teeth, including preoperative and post-operative care, anesthesia, radiology, and pathology services, and facility charges are subject to the deductible, co-insurance and the maximum benefit provisions of the Plan.

D. The provisions of this section shall not apply to Treatment rendered for Temporomandibular Joint (TMJ) diseases or disorders.

VII. Autism Spectrum Disorder (Children under age 17)

Covered expenses incurred for treatment for autism spectrum disorders is payable as shown below for:

1. Charges for habilitative or rehabilitative care, and

2. Charges for therapeutic care

Covered expenses for autism spectrum disorders are payable as shown below, subject to the lifetime maximum of the Plan.

No benefits are payable under this provider for psychiatric care, psychological care or psychiatric providers.

PROVIDER	BENEFIT
In-Network	Same as any other illness
Out-of-Network	Same as any other illness

In-network and Out-of-Network provider covered expenses aggregate to a paid maximum of $36,000 per plan year.

In-network and Out-of-Network provider covered expenses to a paid maximum benefit of $144,000 per lifetime.

VIII. Medicare Reduction

A. If the patient has not chosen and paid a separate premium for the full coordination of benefits option, the charges will be reduced by whatever amounts are paid or payable by Medicare. UnitedHealthcare requires written confirmation from the Social Security Administration or its successor if a person is not eligible for Medicare coverage. All provisions of this Plan, including all limitations and exceptions, will be applied.

B. Retiree 100-Medicare COB - Upon enrollment and payment of the additional monthly premium, a Plan Member and Dependents who are covered under Medicare, both Parts A and B, may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare or within 30 days of retirement if already eligible for Medicare or at the annual enrollment.

IX. Exceptions and Exclusions for All Medical Benefits

No benefits are provided under this Plan for:

A. Cases covered, in whole or in part, by any worker's compensation program, regardless of whether the patient has filed a claim for benefits. This applies to compensation provided on an expense-incurred basis or blanket settlements for past and future losses.

B. Maintenance therapy consisting of convalescent, skilled nursing, sanitarium, custodial care, assisted living facilities, or rest cures designed to assist in daily living activities, maintain present physical and/or mental condition, or provide a structured or safe environment.

C. Expenses for elective, non-therapeutic voluntary abortion, although expenses for complications as a result are covered. (abortions performed for reasons other than to save the life of the mother)

D. Injuries sustained while in an aggressor role.

E. Expenses incurred as a result of a covered persons commission or attempted commission of an illegal act;.

F. Services, supplies, or treatment for cosmetic purposes, including cosmetic surgery and any cosmetic complications of cosmetic surgery, unless necessary for the immediate repair of a deformity caused by a disease and/or injury that occurs while coverage is in force. No payment will be made for expenses incurred in connection with the treatment of any body part not affective by the disease and/or injury.

G. Expenses incurred for shoes and related items similar to wedges, cookies, and arch supports;

H. Dental and orthopedic services, appliances, supplies, and devices, including but not limited to the following:

a. Dental braces and orthopedic appliances, except as specifically provided in Article 3, K, herein;

b. Treatment of periodontal disease;

c. Dentures, dental implants, and any surgery for their use, except if needed as the result of an accident that meets the Program's requirements;

d. Treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in Article 3, BB, herein;

e. Expenses incurred for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, as specifically set forth herein, dental procedures which fall under the guidelines for treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral and maxillofacial

surgeries which are shown to the satisfaction of the Program to be Medically Necessary, non-dental, non-cosmetic procedures;

I. Medical services, treatments, or prescription drugs provided without charge to the Covered Person or for which the Covered Person is not legally obligated to pay.

J. Maternity expenses incurred by any person other than the Employee or the Employee's Legal Spouse.

K. Personal convenience items including, but not limited to, admit kits, bedside kits, telephone and television, guest meals, beds, and charges for luxury accommodations in any hospital or allied health facility provided primarily for the patient's convenience which are not deemed Medically Necessary by UnitedHealthcare.

L. Charges for services and supplies which are in excess of the maximum allowable under UnitedHealthcare's contracted amount, or any other limitations of the Plan.

M. Services , supplies, treatment, drugs, devices, and deluxe medical equipment which are not deemed Medically Necessary by UnitedHealthcare.

N. Services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, Pain Rehabilitation Control and/or Therapy, and dietary or educational instruction for all illnesses, other than diabetes.

O. Services and supplies in connection with or related to gender dysphoria or reverse sterilization.

P. Artificial organ implants, penile implants, transplantation of other than Homo sapiens (human) organs and any surgery and other treatment, services or supplies, related to such procedures, or to complications related to such procedures.

Q. Expenses subsequent to the initial diagnosis for infertility and complications, including, but not limited to, services, drugs, and procedures or devices to achieve fertility; in-vitro fertilization, low tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, donor eggs, and reversal of sterilization procedures.

R. Air conditioners and/or filters, dehumidifiers, air purifiers, wigs or toupees, heating pads, cold devices, home enema equipment, rubber gloves, swimming pools, saunas, whirlpool baths, home pregnancy tests, lift chairs, devices or kits to stimulate the penis, exercise equipment, and any other items not normally considered medical supplies and any items UnitedHealthcare determines are not medical supplies;

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

T. Marriage counseling and/or family relations counseling, divorce counseling, parental counseling, job couseling and career counseling.

U. Charges for services rendered over the telephone from a Physician to a Covered Person.

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

W. Services and supplies related to obesity and/or morbid obesity, surgery for excess fat in any area of the body, resection of excess skin or fat following weight loss or pregnancy.

X. Hearing aids, or any examination to determine the fitting or necessity, except as specifically provided in Article 3, Section I (GG).

Y. Hair plugs and/or transplants.

Z. Routine physical examinations or immunizations not listed under Eligible Expenses.

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

BB. Medical supplies not listed under Eligible Expenses.

CC. Treatment or services for mental health and substance abuse provided outside the treatment plan developed by the Office of Group Benefits' managed care contractor or by therapists with whom or at facilities with which the Program's managed care contractor does not have a contract.

DD. Expenses for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, dental procedures which fall under the guidelines of eligible dental accidents, procedures necessitated as a result of or secondary to cancer, or oral and maxillofacial surgeries which are shown to the satisfaction of UnitedHealthcare to be Medically Necessary, non-dental, non-cosmetic procedures.

EE. Genetic testing, except when determined to be Medically Necessary.

FF. Treatment for Temporomandibular Joint Dysfunction (TMJ), except as listed under Eligible Expenses.

GG. Services of a private-duty Registered Nurse (R.N.) or of a private-duty Licensed Practical Nurse (L.P.N.)

HH. Services rendered by any provider related to the patient by blood, adoption, or marriage.

II. Expenses from a provider who is not licensed in the state where services are rendered.

JJ. Facility fees for services rendered in a physician's office or in any facility not approved by the federal Health Care Finance Administration for payment of such fees under Medicare.

KK. Glucometers

LL. Augmentative communication devices.

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

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

OO. Speech therapy or the services of a speech therapist except as specifically provided in Article 3.

PP. Routine eye examinations, glasses and contact lenses, except as specifically provided for as an Eligible Expense in Article 3.

X. Coordination of Benefits

A. Coordination of benefits is the order of payment when two or more plans are involved. When a patient is also covered by another plan, the plans will coordinate benefits.

B. Benefit plan is this Plan or any one of the following;

1. Group or employer sponsored plan;

2. Group practice and other group prepayment plan;

3. Other plans required or provided by law. This does not include Medicaid or any benefit plan that does not allow coordination.

C. Primary Plan and Secondary Plan

1. All benefits provided are subject to coordination of benefits;

2. Benefit plan payment order:

   a. If an individual is covered by more than one plan, the order of benefit payment will follow guidelines established by the National Association of Insurance Commissioners.

   b. The plan that pays first will pay as if there were no other plan involved. The secondary and subsequent plans may pay the balance due up to 100% of the total allowable expense. No plan will pay benefits greater than it would have paid in the absence of coordination of benefits.

XI. Prescription Drug Benefits

A. This Plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor requiring a prescription and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a Covered Person as an inpatient hospital patient or an outpatient hospital patient, including:

1. Insulin
2. Retin-A dispensed for Covered Persons under the age of 27
3. Vitamin B12 injections
4. Prescription Potassium Chloride
5. Over-the-counter diabetic supplies including, but not limited to, strips, lancets, and swabs

In addition, this Plan allows benefits, not to exceed $200 per month, for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are medically necessary and are obtained from a source approved by the OGB.

Such expenses shall be subject to coinsurance and co-payments relating to prescription drug benefits. In connection with this benefit, the following words shall have the following meanings:

1. "Inherited metabolic disease" shall mean a disease caused by an inherited abnormality of body chemistry and shall be limited to:
   a. Phenylketonuria (PKU).
   b. Maple Syrup Urine Disease (MSUD).
   c. Methylmalonic Acidemia (MMA).
   d. Isovaleric Acidemia (IVA).
   e. Propionic Acidemia.
   f. Glutaric Acidemia.
   g. Urea Cycle Defects.
   h. Tyrosinemia.

2. "Low protein food products" shall mean a food product that is especially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include a natural food that is naturally low in protein.

B. The following drugs, medicines, and related services are not covered:

1. Appetite suppressant drugs
2. Dietary supplements
3. Topical forms of Minoxidil
4. Retin-A dispensed for a Covered Person over age 26
5. Amphetamines dispensed for diagnoses other than Attention Deficit Disorder or Narcolepsy;
6. Nicotine, gum, patches, or other products, services, or programs intended to assist an individual to reduce or cease smoking or other use of tobacco products
7. Nutritional or parenteral therapy
8. Vitamins and minerals
9. Drugs available over the counter
10. Serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting
11. Drugs prescribed for the treatment of impotence, except following the surgical removal of the prostate gland
12. Glucometers.

C. Outpatient prescription drug benefits are adjudicated by a third-party prescription benefits manager with whom the Office of Group Benefits has contracted. In addition to all provisions, exclusions, and limitations relative to prescription drugs set forth elsewhere in this Plan Document, the following apply to expenses incurred for outpatient prescription drugs:

1. Upon presentation of the UnitedHealthcare Identification Card at a network pharmacy, the Plan Member will be responsible for payment of 50 % of the cost of the drug, up to a maximum of $50 dollars per prescription dispensed. The plan will pay the balance of the eligible expense for prescription drugs dispensed at a network pharmacy. There is a $1200 per person per plan year out-of-pocket threshold for eligible prescription drug expenses. Once this threshold is reached, that is, the Plan Member has paid $1200 of coinsurance/co-payments for eligible prescription drug expenses, the Plan Member will be responsible for a $15 co-pay for brand name drugs,

with no co-pay for generic drugs. The plan will pay the balance of the eligible expense for prescription drugs dispensed at a network pharmacy.

2. In the event the Plan Member does not present the UnitedHealthcare identification card to the network pharmacy at the time of purchase, the Plan Member will be responsible for full payment for the drug and must then file a claim with the prescription benefits manager for reimbursement, which will be limited to the rates established for non-network pharmacies.

3. If the Plan Member obtains a prescription drug from a non-network pharmacy in state, reimbursement will be limited to 50% of the amount that would have been paid if the drug had been dispensed at a network pharmacy. If the Plan Member obtains a prescription drug from a non-network pharmacy out of state, benefits will be limited to 80% of the amount that would have been paid if the drug had been dispensed at a network pharmacy.

4. Regardless of where the prescription drug is obtained, eligible expenses for brand-name drugs will be limited to the prescription benefits manager's maximum allowable charge for the drug dispensed.

5. Prescription drug dispensing and refills will be limited in accordance with protocols established by the prescription benefits manager, including the following limitations:

    a. Up to a 30-day supply of drugs may be dispensed upon initial presentation of a prescription or for refills dispensed more than 120 days after the most recent fill;

    b. For refills dispensed within 120 days of the most recent fill, up to a 90-day supply of drugs may be dispensed at one time, provided that co-payments shall be due and payable as follows:

        i. For a supply of 1-30 days the Plan Member will be responsible for payment of fifty (50%) percent of the cost of the drug, up to a maximum of Fifty ($50) Dollars per prescription dispensed;

        ii. For a supply of 31-60 days the Plan Member will be responsible for payment of fifty (50%) percent of the cost of the drug, up to a maximum of One hundred ($100) Dollars per prescription dispensed;

        iii. For a supply of 61-90 days the Plan Member will be responsible for payment of fifty (50%) percent of the cost of the drug, up to a maximum of One hundred fifty ($150) Dollars per prescription dispensed;

        iv. Once the out-of-pocket threshold for eligible prescription drug expenses is reached, the Plan Member's co-payment responsibility for brand drugs will be $15 for a 1-30 days supply, $30 for a 31-60 days supply, and $45 for a 61-90 days supply, with no co-pay for up to a 90 days supply of generic drugs.

6. Brand Drug means the trademark name of a drug approved by the U. S. Food and Drug Administration.

7. Generic Drug means a chemically equivalent copy of a brand drug.

Article 4 – Uniform Provisions

I. Statement of Contractual Agreement

This written Plan Document as amended and any documents executed by or on behalf of the covered Employee constitute the entire agreement between the parties.

II. Properly Submitted Claim

For Plan reimbursements, ALL BILLS MUST SHOW:

- Employee's name
- Name of patient
- Name, address, and telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of service
- Charges
- Employee's member number
- Provider Tax Identification number
- Medicare explanation of benefits, if applicable

UnitedHealthcare can require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish the requested information within 90 days of the request will constitute reason for the denial of benefits.

Submit claims to:
P.O. Box 740800
Atlanta, GA 30374-0800

III. When Claims Must Be Filed

A. A claim for benefits must be received by UnitedHealthcare within 90 days from the date on which the medical expenses were incurred.

B. The receipt date for electronically filed claims is the date on which the program receives the claim, not the date on which the claim is submitted to a clearinghouse or to the provider's practice management system.

IV. Right to Receive and Release Information

UnitedHealthcare may release to or obtain from any company, organization, or person, without consent of or notice to any person, any information regarding any person which UnitedHealthcare deems necessary to carry out the provisions of this Plan, or like terms of any Plan, or to determine how, or if, they apply. Any claimant under this Plan must furnish to the Program any information necessary to implement this provision.

V. Legal Limitations

A Plan Member must exhaust the Administrative Claims Review procedure before filing a suit for benefits. No action shall be brought to recover benefits under this plan more than one year after the time a claim is required to be filed or more than thirty days after mailing of the notice of decision of the Administrative Claims Committee, whichever is later.

Information provided by the Program or any of its employees or agents to Plan Members in any medium other than a written document does not override the terms and provisions of the Plan. In the event of any conflict between the written provisions of this Plan and any verbal information provided, the written provisions of this Plan shall supercede and control.

VI. Benefit Payment to Other Group Health Plans

When payments which should have been made under this Plan have been made by another Group Health Plan, UnitedHealthcare may pay to the other plan the sum proper to satisfy the terms of this Plan Document.

VII. Recovery of Overpayments

If an overpayment occurs, UnitedHealthcare retains the right to recover the overpayment. The Covered Person, institution, or provider receiving the overpayment must return the overpayment. At the Plan's discretion, the overpayment may be deducted from future claims.

Should legal action be required as a result of fraudulent statements or deliberate omissions on the application, the defendant will be responsible for attorney fees of 25 percent of the overpayment or $1,000, whichever is greater. The defendant will also be responsible for court costs and legal interest from date of judicial demand until paid.

VIII. Subrogation and Reimbursement

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

B. The Office of Group Benefits shall be entitled, to the extent of any payment made to a covered Employee, his/her Dependents or other Covered Persons, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a covered Employee, his/her Dependents or other Covered Persons, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made. To this end, covered Employees, their Dependents or other Covered Persons agree to immediately notify the Office of Group Benefits of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident or injury.

C. These subrogation and reimbursement rights also apply when a Covered Person recovers under, but not limited to, an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

IX. Employer Responsibility

A. It is the responsibility of the Participant Employer to submit enrollment and change forms and all other necessary documentation on behalf of its employees to the Office of Group Benefits. Employees of a Participant Employer will not, by virtue of furnishing any documentation to the Office of Group Benefits on behalf of a Plan Member, be considered agents of the Office of Group Benefits, and no representation made by any such person at any time will change the provisions of this Plan.

B. A participant employer shall immediately inform the OGB Program whenever a retiree with OGB coverage returns to full-time employment. The employee shall be placed in the Re-employed Retiree category for premium calculation. The Re-employed Retiree premium classification applies to retirees with Medicare and without Medicare. The premium rates applicable to the Re-employed Retiree premium classification shall be identical to the premium rates applicable to the classification for Retirees without Medicare.

C. Any participant employer that receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the Office of Group Benefits, MSP Adjuster, within 15 days of receipt. If timely forwarded to OGB, then OGB will assume responsibility for any medical benefits, interest, fines or penalties due to Medicare for a covered employee. If not timely forwarded to OGB, then OGB will assume responsibility only for Covered Plan Document medical benefits due to Medicare, for a covered employee. The participant employer will be responsible for any interest, fines or penalties due.

X. Program Responsibility

UnitedHealthcare will administer the Plan in accordance with the terms of the Plan Document, state and federal law, and its established policies, interpretations, practices, and procedures. UnitedHealthcare will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to Covered Person's rights, and to decide questions of Plan Document interpretation and those of fact relating to the Plan Document.

XI. Reinstatement to Position Following Civil Service Appeal

A. Indemnity Plan Participants

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

XII. Plan Document and/or Contract Amendments or Termination

The Office of Group Benefits has the statutory responsibility of providing health and accident and death benefits for Covered Persons to the extent that funds are available. The Program reserves to itself the right to terminate or amend the eligibility and benefit provisions of its Plan Document from time to time as it may deem necessary to prudently discharge its duties. Termination or modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any participant, whether active or retired.

Article 5 – Questions and Appeals

To resolve a question or appeal, follow these steps:

I. What to do First

If your question or concern is about a benefit determination, you may informally contact Customer Care before requesting a formal appeal. If the Customer Care representative cannot resolve the issue to your satisfaction over the telephone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in "How to File a Claim," you may appeal it as described below, without first informally contacting Customer Care. If you first informally contact Customer Care and later wish to request a formal appeal in writing, you should contact Customer Care and request an appeal. If you request a formal appeal, Customer Care representatives will provide you with the appropriate address of the Claims Administrator.

If you are appealing an urgent claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Care immediately.

The Customer Care telephone number **1-866-336-9374**. Customer Care is available to take your call during regular business hours, Monday through Friday.

II. How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim of determination after following the above steps, you can contact UnitedHealthcare in writing to formally request an appeal.

UnitedHealthcare
P.O Box 30432
Salt Lake City, UT 84130

Your request should include:

A. Patients name and ID number from the ID card

B. Date(s) of medical service(s)

C. Physician's name

D. Reason your believe the claim should be paid

E. Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to UnitedHealthcare within 180 days after you receive the claim denial.

III. Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a physician or other health care professional with appropriate expertise in the field, who was not involved in the prior determination. UnitedHealthcare (first level appeals) and the Plan Administrator (second level appeals) may consult with, or see the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits.

IV. Appeals Determination

Pre-service and Post-service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows.

For appeals of pre-service claims (as defined in the "How to File a Claim" section), the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of denied claim. The second level appeal will be conducted by the State of Louisiana, Office of Group Benefits and you will be notified by them of the decision within 30 days from the receipt of a request for review of the first level appeal decision.

For appeals of post-service claims (as defined in the "How to File a Claim" section), the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted by the State of Louisiana, Office of Group Benefits and you will be notified by them of the decision within 30 days from the receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of UnitedHealthcare, you have the right to request an appeal from the State of Louisiana, Office of Group Benefits. Your second level appeal request must be submitted to us in writing within 30 days from receipt of the first level appeal decision.

Second level appeals should be sent in writing to:
Office of Group Benefits
Attn: Appeals Department
P. O. Box 44036
Baton Rouge, LA 70804

UnitedHealthcare has the exclusive right to interpret and administer the Plan, and those decisions are conclusive and binding.

Please note that our decision is based only on whether or not the Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician or other health care professional.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call UnitedHealthcare as soon as possible. UnitedHealthcare will provide you with a written or electronic determination within 72 hours following receipt by UnitedHealthcare of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions under the Plan. UnitedHealthcare's decisions are conclusive and binding.

For urgent claim appeals, call **1-866-823-1807**.

General Legal Provisions

I. Plan Document

This Benefit Summary presents an overview of your Benefits. In the event of any discrepancy between this Benefit Summary and the Plan Document, the Plan Document shall govern.

II. Relationships with Physicians

The relationships between the Office of Group Benefits, UnitedHealthcare and network physicians are solely contractual relationships between independent contractors. Network physicians or other health care professionals are not our agents or employees. Nor are they agents or employees of UnitedHealthcare. Neither we nor any of our employees are agents or employees of network physicians.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Network physicians or other health care professionals are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about physicians' licenses and other credentials, but does not assure the quality of the services provided. Network physicians and other health care professionals are not our employees or employees of UnitedHealthcare, nor do we have any other relationship with network physicians or other health care professionals such as principal-agent or joint venture. Neither we nor UnitedHealthcare are liable for any act or omission of any physician or health care professional.

UnitedHealthcare is not considered to be an employer of the Office of Group Benefits or for any purpose with respect to the administration or provision of Benefits under this Plan.

A. Enrollment and classification changes (including classification changes resulting in your enrollment on the termination of your coverage).

B. The timely payment of Benefits.

C. Notifying you of the termination or modifications to the Plan.

III. Your Relationship with your Physician

The relationship with between you and your physician is that of physician and patient.

A. You are responsible for choosing your own physician

B. You must decide if any physician treating you is right for you. This includes network physicians you choose and physicians to whom you have been referred.

C. You must decide with your physician what care you should receive.

D. You physician is solely responsible for the quality of services provided to you.

The relationship between you and us is that of employer and employee, dependent or other classification as described in the Plan.

IV. Incentive to Physicians

UnitedHealthcare pays network physicians through various types of contractual arrangements, some of which may include financial incentives to promote delivery of health care in a cost-efficient and

effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives to Network Physicians include:

A. Bonuses for performance based on factors that may include quality, member satisfaction and/or cost effectiveness.

B. Capitation in which a group of Network Physicians receives a monthly payment for each Covered Person, who selects a Network Physicians within the group to perform or coordinate certain health services. The Network Physicians receive this monthly payment regardless of whether the cost of providing or arranging to provide the covered person's health care is less than or more than the payment.

The methods used to pay specific Network physicians may vary. From time to time, the payment method may change. If you have questions about whether your Network physician's contract includes any financial incentives, we encourage you to discuss those questions with your physician. You also may contact UnitedHealthcare at the telephone number on the back of your member ID card. They can advise whether your Network physician is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

V. Incentives to You

Sometimes UnitedHealthcare may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not participate is yours alone, but we recommend you discuss participating in such programs with your physician. These incentives are not Benefits, and do not alter or affect your Benefits. Contact UnitedHealthcare if you have any questions.

VI. Interpretation of Benefits

The Office of Group Benefits and UnitedHealthcare have sole and exclusive discretion to do all the following:

A. Interpret Benefits under the Plan

B. Interpret the other terms, conditions, limitations and exclusions of the Plan, including this benefit summary and any riders and amendments.

C. Make factual determinations related to the Plan and its Benefits

The Office of Group Benefits and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiencies, we may in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Glossary

Accidental Injury means 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, the act of chewing does not constitute an injury caused by external force.

Autism means a condition affecting a *covered person* ages two (2) through twenty-one (21) years of age, which includes:

(A) A total of six (6) or more items from subparagraphs 1, 2, and 3 of this paragraph, with at least two (2) from subparagraph 1 and one (1) each from subparagraphs 2 and 3:

1. Qualitative impairment in social interaction, as manifested by at least two (2) of the following:

   a. Marked impairment in the use of multiple nonverbal behavior such as eye-to-eye gaze, facial express, body postures, and gestures to regulate social interaction;

   b. Failure to develop peer relationships appropriate to developmental level;

   c. A lack of spontaneous seeking to share enjoyment, interests or achievement with other people; or

   d. Lack of social or emotional reciprocity.

2. Qualitative impairments in communications as manifested by at least one (1) of the following:

   a. Delay in, or total lack of, the development of spoken language;

   b. In individuals with adequate speech, marked impairment in the ability to imitate or sustain a conversation with others;

   c. Stereotyped and repetitive use of language or idiosyncratic language; or

   d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.

3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one (1) of the following:

   a. Encompassing preoccupation with one (1) or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;

   b. Apparently inflexible adherence to specific, nonfunctional routines or rituals;

   c. Stereotyped and repetitive motor mannerisms; or

   d. Persistent preoccupation with parts or objects.

(B) Delays or abnormal functioning in at least one (1) of the following areas, with onset prior to age three (3) years;

1. Social interaction;

2. Language as used in social communication; or

3. Symbolic or imaginative play; and

(C) The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including autism, Asperger's Disorder and Pervasive Developmental Disorders (not otherwise specified).

Benefit Payment means payment of eligible expenses incurred by a Covered Person during a Plan year at the rate shown under Percentage Payable in the Schedule of Benefits.

Brand Drug means the trademark name of a drug approved by the U. S. Food and Drug Administration.

CEO means the Chief Executive Officer of the Program.

Children means:

1. any legitimate, duly acknowledged, or legally adopted Children of the Employee and/or the Employee's legal spouse dependent upon the Employee for support;

2. any Children in the process of being adopted by the employee through an agency adoption who are living in the household of the Employee and who are or will be included as a Dependent of the Employee's federal income tax return for the current or next tax year (if filing is required);

3. other Children for whom the Employee has legal custody, who live in the household of the Employee, and who are or will be included as Dependents on the Employee's federal income tax return for the current or next tax year (if filing is required);

4. grandchildren for whom the Employee does not have legal custody, who are dependent upon the Employee for support, and one of whose parents is a covered Dependent. If the Employee seeking to cover a grandchild is a paternal grandparent, the Program will require that the biological father, i.e. the covered son of the Plan Member, execute an acknowledgement of paternity. If dependent parent becomes ineligible, the grandchild becomes ineligible for coverage, unless the Employee has legal custody of the grandchild.

COBRA means federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 with amendments.

Committee means the Administrative Claims Committee.

Contracted Rates means the schedule of maximum allowable charges for professional or hospital services adopted and promulgated by UnitedHealthcare.

Covered Person means an active or retired Employee, or his eligible Dependent, or any other individual eligible for coverage for which the necessary application forms have been completed and for whom the required contribution is being made.

Custodial Care means care designed essentially to assist an individual to meet his 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 the hospital or other institution for the treatment of a disease, illness, accident, or 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 incapacitated and who is not under specific medical, surgical, or psychiatric treatment to reduce the incapacity to the extent necessary to enable the patient to live outside an institution providing medical care, or when, despite treatment, there is not reasonable likelihood that the incapacity will be so reduced.

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

1. Legal Spouse – date of marriage;

2. Children –

    a) Natural Children – the date of birth;

    b) Children in the process of being adopted:

        1) Agency adoption – the date the adoption contract was executed by the Employee and the adoption agency;

        2) Private adoption – the date of the execution of the Act of Voluntary Surrender in favor of the Employee, if the Program is furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date that said Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;

    c) Other Children living in the household of the covered Employee who are or will be included as a Dependent on the Employee's federal income tax return – the date of the court order granting legal custody.

    d) Grandchildren for whom the Employee does not have legal custody, who are dependent upon the Employee for support, and one of whose parents is a covered Dependent as defined:

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

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

Deductible means the amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Plan year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

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

1. the covered Employee's legal spouse;

2. any never married Children from date of birth (must be added to coverage by completing appropriate enrollment documents) up to 21 years of age, dependent upon the Employee for support;

3. any never married children 21 years of age, but less than 24 years of age, who are enrolled and attending classes as full-time students and who depend upon the employee for support. The term full-time student means students who are enrolled at an accredited college or university, or at a vocational, technical, or vocational-technical or trade school or institute, or secondary school, for the number of hours or courses which is considered to be full-time attendance by the institution the student is attending;

   It is the responsibility of the Plan Member to furnish proof acceptable to the Office of Group Benefits documenting the full-time student status of a dependent child for each semester.

4. A never married Child of any age who meets the criteria set forth in Article 1 Section II (D) herein.

Dependent Coverage means benefits with respect to the Employee's Documented Dependents only.

Disability means that the Covered Person, if an Employee, is prevented, solely because of a disease, illness, accident, or injury from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit; or, if a Dependent, is prevented solely because of a disease, illness, accident, or injury, from engaging in substantially all the normal activities of a person of like age in good health.

Documented (with respect to a *dependent* of an *employee*) means the following written proof of relationship to the *employee* has been presented for inspection and copying to OGB, or to a representative of the *employee's* participant employer designated by OGB:

1. The covered *employee's* legal spouse – certified copy of certificate of marriage indicating date and place of marriage;

2. Never-married child under age 21 who is *dependent* on the *employee* for support –

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

   b. Stepchild – Certified copy of certificate of marriage to spouse and birth certificate listing spouse as natural or adoptive parent;

   c. *Child* placed with *your* family for adoption by agency adoption or irrevocable act of surrender for private adoption who lives in *your* household and/or will be included as *dependent* on *your* federal income tax return for current or next tax year – Certified copy

of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender;

d. *Child* for whom *you* have been granted guardianship or legal custody, including provisional custody, who lives in *your* household and/or will be included as *dependent* on *your* federal income tax return for current or next tax year – Certified copy of signed legal judgment granting *you* legal guardianship or custody, or the original notarized act granting provisional custody in proper statutory form;

e. Grandchild for whom *you* do not have legal custody or guardianship but who is *dependent* on *you* for support and whose parent is a covered *dependent* – Certified birth certificate or adoption decree showing parent of grandchild is *dependent child* and certified copy of birth certificate showing *dependent child* is parent of grandchild;

3. Never-married *child* over age 21 but under age 24 years of age, who is enrolled and attending classes as a full time student and is *dependent* on *you* for support – Documentation as described in 2a through 2d above together with written certification of full-time student from registrar status within 30 days of start date of each semester/quarter;

4. Never-married *child* age 21 or older who is incapable of self-sustaining employment due to mental retardation or physical incapacity who was covered prior to age 21 – Documentation as described in 2a through 2d above together with an application for continued coverage supporting medical documentation prior to the *child's* attainment of age 21 as well as additional medical documentation of *child's* continuing condition periodically upon request by OGB;

5. Such other written proof of relationship to the *employee* deemed sufficient by OGB.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of a illness or injury and (d) is appropriate for use in the home. Durable Medical Equipment includes, but is not limited to, such items as wheelchairs, hospital beds, respirators, braces (nondental), and other items that the Program may determine to be durable medical equipment.

Emergency Room Services means hospital services eligible for reimbursement, provided at a hospital Emergency Room and billed by a hospital, and provided on an expeditious basis for treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could reasonably result in physical impairment or loss of life.

Employee means a full-time Employee as defined by a Participant Employer and in accordance with state law. No person appointed on a temporary appointment will be considered an Employee.

Employee Coverage means benefits with respect to the Employee only.

EPO (Exclusive Provider Organization) means a medical provider, such as a hospital, doctor or clinic, that enters into a contractual agreement with UnitedHealthcare to provide medical services to covered persons at a reduced or discounted price.

Family Unit Limit means the dollar amount shown in the Schedule of Benefits has been incurred by three members of a family unit toward their Plan year deductibles. The deductibles of all additional members of that family unit will be considered satisfied for that year.

Future Medical Recovery means recovery from another plan of expenses contemplated to be necessary to complete medical treatment of the Covered Person.

Generic Drug means a chemically equivalent copy of a "brand name" drug.

Group Health Plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Health Insurance Coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described pursuant to the Health Insurance Portability and Accountability Act is not treated as benefits consisting of medical care.

Health Maintenance Organization (HMO) means any legal entity which has received a certificate of authority from the Louisiana Commissioner of Insurance to operate as a health maintenance organization in Louisiana.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (USA Public Law 104- 191).

Hospital means an institution which meets the entire following requirement:

Is currently licensed as a hospital by the state in which services are rendered and is not primarily an institution for rest, the aged, the treatment of pulmonary tuberculosis, a nursing home, extended care facility or remedial training institution, or a facility primarily for the treatment of conduct and behavior disorders.

Incurred Date means the date upon which a particular service or supply is rendered or obtained. When a single charge is made for a series of services; each service will bear a pro rated share of the charge.

Inpatient Confinement means a hospital stay that is equal to or exceeds 24 hours.

Lifetime Maximum Benefit means the total amount of benefits that will be paid under the Plan for all eligible expenses incurred by a Covered Person.

Medically Necessary means a service or treatment which, in the judgement of the Program:

1. is appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

2. is not primarily Custodial Care.

Medicare means the health insurance available through Medicare laws enacted by the Congress of the United States.

Network Pharmacy means a pharmacy which participates in a network established and maintained by a prescription benefits management firm with which the Program has contracted to provide and administer outpatient prescription drug benefits.

Occupational Therapy means the application of any activity in which one engages for the purposes of evaluation, interpretation, treatment planning, and treatment of problems interfering with functional performance in persons impaired by physical illness or injury in order to significantly improve functioning.

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

Outpatient Surgical Facility means an ambulatory surgical facility licensed by the state in which the services are rendered.

Pain Rehabilitation Control and/or Therapy means any program designed to develop the individual's ability to control or tolerate chronic pain.

Participant Employer means a state entity, school board, or a state political subdivision authorized by law to participate in the Program.

Physical Therapy means the evaluation of physical status as related to functional abilities and treatment procedures as indicated by that evaluation.

Physician means the following persons, licensed to practice their respective professional skills by reason of statutory authority:

1. doctors of medicine (M.D.);
2. doctors of dental surgery (D.D.S.);
3. doctors of dental medicine (D.M.D.);
4. doctors of osteopathy (D.O.);
5. doctors of podiatric medicine (D.P.M.);
6. doctors of chiropractic (D.C.);
7. doctors of optometry (O.D.);
8. psychologists meeting the requirements of the National Register of Health Service Providers in Psychology;
9. board certified social workers who are a members of an approved clinical social work registry or employed by the United States, the State of Louisiana, or a Louisiana parish or municipality, if performing professional services as a part of the duties for which he is employed;
10. mental health counselors who are licensed by the state in which they practice.
11. substance abuse counselors who are licensed by the state in which they practice.

The term Physician does not include social workers who are not board certified, interns, residents, or fellows enrolled in a residency-training program regardless of any other title by which they are designated or the position on the medical staff of a hospital. A senior resident, for example, who is referred to as an assistant attending surgeon or an associate physician, is considered a resident since the senior year of the residency is essential to completion of the training program. Charges made by a physician who is on the faculty of a state medical school or on the staff of a state hospital will be considered a covered expense if the charges are made in connection with the treatment of a disease, illness, accident, or injury covered under this Plan, and if the physician would have charged a fee for the services in the absence of this provision.

> It is the specific intent and purpose of the Program to exclude reimbursement to the Covered Person for services rendered by social workers who are not board certified, and interns, residents, or fellows enrolled in a residency training program regardless of whether the intern, resident, or fellow was under supervision of a physician, or regardless of the circumstances under which services were rendered. The term physician does not include a practicing medical doctor in the capacity of supervising interns, residents, senior residents, or fellows enrolled in a training program that does not personally perform a surgical procedure or provide medical treatment to the Covered Person.

Plan means coverage under this contract including EPO benefits, prescription drug benefits, mental health and substance abuse benefits, and comprehensive medical benefits.

Plan Member means a Covered Person other than a Dependent

Plan Year means that period commencing at 12:01 a.m., JULY 1, standard time, at the address of the Employee, or the date the Covered Person first becomes covered under the Plan and continuing until 12:01 a.m., standard time, at the address of the Employee on the next following JULY 1. Each successive Plan year will be the period from 12:01 a.m., JULY 1, standard time, at the address of the Employee to 12:01 a.m., the next following JULY 1

PPO means a Preferred Provider Organization. A PPO is a medical provider such as a hospital, doctor, or clinic who entered into a contractual agreement with UnitedHealthcare to provide medical services to Covered Persons at a reduced or discounted price.

Program means the Office of Group Benefits program.

Recovery means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or sickness whether or not said losses reflect medical or dental charges covered by UnitedHealthcare.**Rehabilitation and Rehabilitation Therapy** means care concerned with the management of patients with impairments of function due to disease, illness, accident, or injury.

Reimbursement means repayment to the Office of Group Benefits for medical or dental benefits that it has paid toward care and treatment of the injury or sickness.

Rest Cure means care provided in a sanitarium, nursing home or other facility and designed to provide custodial care and provide for the mental and physical well being of an individual.

Retiree means an individual, who was a covered Employee immediately prior to the date of retirement and who, upon retirement,

1. immediately received retirement benefits from an approved state or governmental agency defined benefit plan; or,

2. was not eligible for participation in such a plan or had legally opted to not participate in such a plan; and

   a) began employment prior to September 15, 1979, has 10 years of continuous state service and has reached the age of 65; or

   b) began employment after September 16, 1979, has 10 years of continuous state service and has reached the age of 70; or

   c) was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment and has reached the age of 65; or

   d) maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan; or

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

4. Retiree also means an individual who was a covered Employee who continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items 1, 2 or 3, above.

Room and Board means all hospital expenses necessary to maintain and sustain a Covered Person during a confinement, including but not limited to, facility charges for the maintenance of the Covered Person's hospital room, dietary and food services, nursing services performed by nurses employed by or under contract with the hospital, and housekeeping services.

Stop Loss Provision represents the co-insurance amount for which the Plan Member is responsible. This amount does not include any deductibles or ineligible expenses. The Plan Member's Stop Loss will be the difference between UnitedHealthcare's payment and the eligible charge.

Subrogation means the Office of Group Benefits' right to pursue the Covered Person's claims for medical or dental charges against a liability insurer, a responsible party, or the Covered Person.

Temporary Appointment means an appointment to any position for a period of 120 consecutive calendar days or less.

Treatment includes consultations, examinations, diagnoses, and medical services rendered in the care of a Covered Person.

Well-Adult Care means a routine physical examination by a physician. It may include an influenza vaccination, lab work and X-rays performed as part of the exam. The health care provider who has entered into a contract with UnitedHealthcare must submit the bill with wellness procedure and diagnosis codes. All other health services coded with wellness procedures and diagnosis codes are excluded.

Well-Baby Care means routine care to a well newborn infant from the date of birth until age 1. This includes routine physical examinations, active immunizations, check-ups, and office visits to a physician and billed by that physician, except for the treatment and/or diagnosis of a specific illness. All other health services coded with wellness procedures and diagnosis codes are excluded.

Well-Child Care means routine physical examinations, active immunizations, check-ups, and office visits to a Physician, and billed by a health care provider who has entered into a contract with UnitedHealthcare, except for the treatment and/or diagnosis of a specific illness, from age 1 through age 15. All other health services coded with wellness procedures and diagnosis codes are excluded.

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under a group health plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that the Office of Group Benefits may maintain and that provides medical care. For simplicity, any such group health plan is referred to in this Notice as the "Plan." You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay the entire premium for your continuation coverage.

This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly. This notice is only a summary, subject to change for legislation, administrative rulings, etc.

Both you (the employee) and your spouse should read this summary carefully and keep it with your records.

Qualifying Events

If you are eligible to participate in the Plan due to your employment and are covered by the Plan, you are a qualified beneficiary and you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Termination of your employment (for reasons other than gross misconduct).

2. Reduction in the hours of your employment.

If you are the spouse of an employee covered by the Plan, you are a qualified beneficiary and you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your spouse.

2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Employer.

3. Divorce or legal separation from your spouse. (Also, if an employee eliminates coverage for his spouse in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

4. Your spouse becoming entitled to Medicare benefits.

In the case of a dependent child of an employee covered by the Plan, he is a qualified beneficiary and he has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

1. The death of the employee parent.

2. The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment with the Employer.

3. Parents' divorce or legal separation.

4. The employee parent becoming entitled to Medicare benefits.

5. The dependent ceasing to be a "dependent child" under the Plan.

The option to elect COBRA coverage applies only upon the occurrence of a qualifying event, as discussed above. Retirees, their spouses, and

their dependent children may have similar rights if an employer can no longer fund its portion of the premiums, causing a loss of coverage.

IMPORTANT: Your Notice Obligations
If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation, or the child's losing dependent status under the Plan, then under the COBRA statute, you (the employee) or your spouse or dependent has the responsibility to notify the Office of Group Benefits of the divorce, legal separation, or the child's losing dependent status. You or your spouse or dependent must provide this notice no later than 60 days after the date coverage terminates under the plan (see your plan document for details regarding when plan coverage terminates). *If you or your spouse or dependent fails to provide this notice to the Office of Group Benefits during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse or dependent fails to provide this notice to the Office of Group Benefits, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child's losing dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

If the Office of Group Benefits is timely provided with notice of a divorce, legal separation, or a child's losing dependent status that has caused a loss of coverage, then the Office of Group Benefits will notify the affected family member of the right to elect continuation coverage (but only to the extent that the Office of Group Benefits has been notified in writing of the affected family member's current mailing address—see YOU MUST NOTIFY US paragraph below).

You (the employee) and your spouse and dependent children will also be notified of the right to elect continuation coverage upon the following events that result in a loss in coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, or death, or the employee's becoming entitled to Medicare.

Election Procedures
You (the employee) and/or your spouse and dependent children must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Office of Group Benefits provides you or your family member with notice of the right to elect continuation coverage. *If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* A COBRA election mailed to the Office of Group Benefits is considered to be made on the date of the mailing.

You (the employee), your spouse, and dependent children each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered employee does not (or is not deemed to) elect it. Unless the election specifies that it is for self-only coverage, your election or your spouse's election will apply to all covered beneficiaries. You and/or your spouse may elect continuation coverage for all qualifying family members.

You (the employee) and/or your spouse and/or dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse, or dependent children had on the day before the qualifying event. Therefore, an employee, spouse or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce.

If the coverage is modified for similarly-situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If the Employer maintains more than one group health plan, you (or your spouse or dependent children) may elect COBRA coverage under any one or more of those plans in which you have coverage. For example, if you are covered under three separate Employer plans, a medical plan, a dental plan, and a vision plan, you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans.

If the Employer maintains a health flexible spending account (health FSA) under a cafeteria plan where you are reimbursed for medical expenses from a "flex account," you (or your spouse or dependent children) may have a right to elect to continue the health FSA coverage under COBRA. However, that right may be limited to those who have a positive account balance (i.e., year-to-date contributions exceed year-to-date claims) on the day before the date of the qualifying event (taking into account all claims submitted on or before that date). Furthermore, that COBRA coverage under the health FSA may be available only for the remainder of the Plan year in which your qualifying event occurred. Please contact your health FSA Plan Administrator for information regarding your health FSA COBRA rights.

COBRA Premiums You Must Pay

The premium payments for the "initial premium months" must be paid for you (the employee) and for any spouse or dependent child by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made.

Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial

premium month until that month's premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is considered to be made on the date it is sent. If you do not make the full premium payment by the due date, then your COBRA coverage will be canceled at the beginning of the 30 day grace period and reinstated if payment is received within the 30 day grace period.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA can be cut off before the maximum period expires in certain situations described later under the heading "Termination of COBRA before the End of the Maximum Coverage Period."

36 Months. If you (the spouse or dependent child) lose group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lose your status as a dependent under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date that coverage is lost.

18 Months. If you (the employee, spouse, or dependent child) lose group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period (for the employee, spouse, and dependent child) is 18 months from the date that coverage is lost. There are three exceptions:

- If an employee or family member is disabled at any time during the first 60 days of continuation coverage (that is, within 60 days after the date coverage would have terminated, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the

  date coverage is lost. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began, except in the case of a person who is ineligible for Social Security Disability due to insufficient "quarters" of employment. In that case, the staff and Medical Director of the Office of Group Benefits will make the determination of total disability. For the 29- month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Office of Group Benefits within the 18-month coverage period and 60 days after the date of the determination. However, in the case of a person who is ineligible for Social Security Disability due to insufficient "quarters" of employment, proof of total disability must be submitted before the initial 18-month continued coverage period expires.

- If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date that coverage is lost.

- If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and dependent child) ends three years from the date the employee became entitled to Medicare.

Shorter Maximum for Health FSAs. The maximum COBRA period for a health flexible spending arrangement (health FSA) if a positive account balance is required (as explained above) ends on the last day of the Plan year in which the qualifying event occurred.

Children Born to or Placed for Adoption with the Covered Employee during COBRA Period
A child born to, adopted by, or placed for adoption with a covered employee during a period of continuation coverage is considered a qualified beneficiary provided that, where the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan and it lasts for as long as COBRA coverage lasts for other family members of the employee. If the child is enrolled within 30 days of his birth, adoption, or placement for adoption, the child's coverage will not be subject to a pre-existing condition limitation. To be enrolled in the Plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

Annual Enrollment Rights and HIPAA Special Enrollment Rights
Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, birth, adoption, or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children Born to or Placed for Adoption With the Covered Employee After the Qualifying Event," dependents who are added under HIPAA's special enrollment rights do not become qualified beneficiaries—their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them.

Alternate Recipients Under QMCSOs
A child of yours (the employee's) who is receiving benefits under the Plan pursuant to a

Qualified Medical Child Support Order (QMCSO) received by the Office of Group Benefits during your (the employee's) period of employment with the employer is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependent.

Termination of COBRA before the End of Maximum Coverage Period
Continuation coverage of the employee, spouse, and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

1. The Employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the employee, spouse or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his creditable health plan coverage prior to enrolling in the other group health plan.)

4. After electing COBRA coverage, you (the employee, spouse, or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the employee, spouse, or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the mont that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Notify Us about Address Changes, Marital Status Changes, Dependent Status Changes, and Disability Status Changes

If you or your spouse's address changes, you must promptly notify the Office of Group Benefits in writing. (The Office of Group Benefits needs up-to-date addresses in order to mail important COBRA and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or dependent must promptly notify the Office of Group Benefits in writing. (Such notification is necessary to protect COBRA rights for your spouse and dependent children). Furthermore, you must notify us if you (the employee, spouse, or dependent child) become entitled to Medicare and you must notify us if a disabled employee or family member is determined to be no
longer disabled.

Plan Administrator

The Office of Group Benefits is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to:

Office of Group Benefits
Eligibility Department
P. O. Box 44036
Baton Rouge, Louisiana 70804
225.925.6151

For More Information

If you, your spouse, or dependent children have any questions about this notice or COBRA, please contact the Office of Group Benefits.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits also are provided for the following Covered Health Services, as you determine appropriate with your attending physician:

1. All stages of reconstruction of the breast on which the mastectomy is performed

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance

3. Prostheses and treatment of physical complications of the mastectomy, including lymphedema

The amount you must pay for such Covered Health Services (including copayments and deductibles) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same for any other covered health service.

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

Group health Plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, Plans and issuers may not, under Federal law, require that a physician obtain authorization from the Plan or the insurance issuer fro prescribing a length of stay not in excess of 48 hours (or 96 hours).