2005-06 Plan Year

Choice This Plan year all regions of the state will have

PPO administered by the OGB statewide

EPO administered by United Health Care nationwide

HMO administered by Humana in regions 1-8; adminstered by Vantage in region 9

MCO administered by FARA statewide, with a more limited formulary

The purpose of this booklet is to provide “helpful information” to valued OGB Plan Members to give you a quick reference guide.

For full details on your plan, refer to the complete, official **PLAN DOCUMENT** that features all of the pertinent details surrounding that plan.

For ongoing information please visit our website, at **www.groupbenefits.org.**

Medical Benefits Comparison/Active

COVERED BENEFIT: IN NETWORK	OGB PPO Plan All Regions	EPO Plan (Administered by UHC) Nationwide
Lifetime Maximum Benefit	$1 million per person	$2 million per person
Plan Year Deductible Employees and dependents	$500/active; $300 retired Family Unit Maximum: 3 individual deductibles	$300/active & retired; non-Co-pay services Family Unit Maximum : 3 individual deductibles
Maximum Out-Pocket Expense in Network	$1000 per person	N/A
Hospital Services (inpatient)	Plan covers 90% of Contracted Rate[1, 2]	$100 per day[2] Max of $300 per admission
Surgeon, Anesthesia, Lab, & X-rays	Plan covers 90% of Contracted Rate[1]	Plan Covers at 100%[1]
Hospital Emergency Room (facility only)	$150 separate deductible/waived if admitted[1 2] Plan covers 90% of Contracted Rate[1]	$100 Co-pay/waived if admitted (Hospital Co-pay applies)[2]
Ambulatory Surgical Facilities	Plan covers 90% of Contracted Rate[1]	$100 Co-pay
Physician Visits	Plan covers 90% of Contracted Rate[1]	$15 PCP/$25 Specialist (no referral required)
Maternity (physician only)	Plan covers 90% of Contracted Rate[1]	$90 Co-pay
MRI/Cat Scan	Plan covers 90% of Contracted Rate[1,]	$50 Co-pay
Sonograms	Plan covers 90% of Contracted Rate[1]	$25 Co-pay
Chemical/Radiation Therapy	Plan covers 90% of Contracted Rate[1]	Plan covers at 100%[1]
Dialysis[2]	Plan covers 90% of Contracted Rate[1]	Plan covers at 100%[1]
Pre-admission Testing	Plan covers 90% of Contracted Rate[1]	Plan covers at 100%[1]
Cardiac Rehabilitation Therapy	Plan covers 90% of Contracted Rate[1] (within 6 months)	$15 Co-pay (within 6 months)
Physical and Occupational Therapy	Plan covers 90% of Contracted Rate[1]	$15 Co-pay
Speech Therapy[2]	Plan covers 90% of Contracted Rate[1]	$15 Co-pay
Oral Surgery (impacted tooth removal only)	Plan covers 100% of Fee Schedule	Plan covers 100% of Fee Schedule
Routine PAP Test	Plan covers 90% of Contracted Rate[4]	Plan covers at 100%; one every 12 months
Routine Mammogram	Plan covers 90% of Contracted Rate[4]	Plan covers at 100%[4]
Routine PSA Screening	Plan covers 90% of Contracted Rate[4]	Plan covers at 100%[4]; one every 12 months
Ambulance (transportation only) ground Licensed Air Ambulance	Plan considers a maximum to $350[3] less a $50 co-payment Plan considers a maximum to $1500[3] less a $250 co-payment	Plan considers a maximum to $350[3] less a $50 co-payment Plan considers a maximum to $1500[3] less a $250 co-payment
Durable Medical Equipment $50,000 Lifetime Maximum per person	Plan covers 90% of Contracted Rate[1]	Plan covers 80% of Contracted Rate[1]
Home Health Care[2] Limited to 150 visits year	Case Management Required Plan covers 70% of negotiated rate[1]	Case Management Required $15 Co-pay
Hospice Care[2]	Case Management Required Plan covers 80% of negotiated rate	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	 Plan covers 90% of Contracted Rate[1] 100% of eligible expenses to $200[4] N/A	 $15 Co-pay for PCP Visits[1] 100% of eligible expenses to $200[4] N/A
Prescription Drug Benefit In Network	Lifetime maximum: $250,000 per person Member pays 50%; max. $50 per 34 day fill After $1200 per person per plan year Co-pay Brand - $15, Generic -$0	Lifetime maximum: $250,000 per person Member pays 50%; max. $50 per 34 day fill After $1200 per person per plan year Co-pay Brand - $15, Generic -$0
Mail Order Drug Program	same as above	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	Plan covers at 80% Separate $200 deductible (in & out patient) Inpatient-$50 per day-Max. 5days
Mental Health & Substance Abuse/Outpatient[2] max. 52 visits/year	Plan covers at 80%	Plan covers at 80%
COVERED BENEFIT: OUT-OF-NETWORK		
Member resides in Louisiana	Plan covers 70% of fee schedule[1]	Separate $300 deductible Plan covers 70% of fee schedule[1]
Member resides outside of Louisiana	Plan covers 90% of fee schedule[1]	Separate $300 deductible Plan covers 70% of fee schedule[1]

[1] Subject to plan year deductible and/or applicable co-insurance

[2] Pre-authorization required

[3] Medical Supplies are subject to deductible and co-insurance

[4] Age and/or time restrictions apply

Humana HMO Regions 1-8	**Vantage HMO** Region 9	**MCO Plan (Administered by FARA)** All Regions
None	$2 million per person	$1 million per person
None	None	None
$1000 per person/$3000 Family	N/A	N/A
$100 per day Max of $300 per admission	$100 per day[2] Max of $300 per admission	$100 Co-pay per day[2] Max of $300 per admission
Plan Covers at 100%	Plan Covers at 100%	Plan covers at 100%
$100 Co-pay/waived if admitted (Hospital Co-pay applies)[2]	$100 Co-pay/waived if admitted (Hospital Co-pay applies)[2]	$100 Co-pay/waived if admitted (Hospital Co-pay applies)[2]
$100 Co-pay	$100 Co-pay	$100 Co-pay
$15 PCP/ $25 Specialist (no referral required)	$15 PCP/$25 Specialist (referral required)	$15 PCP/$25 Specialist(no referral required)
$90 Co-pay	Plan covers at 100%[2]	$90 Co-pay
$50 Co-pay	Plan covers at 100%[2]	$50 Co-pay[2]
$25 Co-pay	Plan covers at 100%[2]	$25 Co-pay
$15 Co-pay	Plan covers at 100%[2]	Plan covers at 100%[2]
Plan covers at 100%[2]	Plan covers at 100%[2]	Plan covers at 100%[2]
Plan covers at 100%	Plan covers at 100%[2]	Plan covers at 100%[2]
$15 Co-pay	Plan covers at 80% (18 visits)[2]	$15 Co-pay
$15 Co-pay	Plan covers at 80% (20 visits)[2]	$15 Co-pay[2]
$15 Co-pay	Plan covers at 80% (20 visits)[2]	$15 Co-pay[2]
Plan covers at 100%[2]	Plan covers at 80%[2]	Plan covers at 100%
Plan covers at 100% after Co-pay	Plan covers at 100%	Plan covers at 100%
Plan covers at 100%	Plan covers at 100%	Plan covers at 100%[4]
Plan covers at 100%	Plan covers at 100%	Plan covers at 100%[4]
Plan considers a maximum to $350 less a $50 co-payment Plan considers a maximum to $1500 less a $250 co-payment	Plan pays 80% interfacility transfers 100%	Plan considers a maximum to $350 less a $50 co-payment Plan considers a maximum to $1500 less a $250 co-payment
Plan covers 80% of Contracted Rate	Plan covers 80% of Contracted Rate[2]	Plan covers 80% of Contracted Rate[2]
Plan Covers at 100%	Plan covers at 100%	Plan covers at 100%
Plan covers at 100%	Plan covers at 100%	Plan covers at 100%
$15 Co-pay	$15 Co-pay	$15 Co-pay Age limitations apply
$15 Co-pay	$15 Co-pay	$15 Co-pay Eligible Expenses to $200[4]
$15 Co-pay	N/A	N/A
Lifetime maximum: $250,000 per person Member pays 50%; max. $50 per 30 day fill After $1200 per person per plan year Co-pay Brand - $15, Generic -$0 Formulary applies	 Generic - $10 Co-pay Preferred - $25 Co-pay Non-preferred - $40 Co-pay Formulary applies Mandatory Generic required	Lifetime maximum: $250,000 per person Member pays 50%; max. $50 per 34 day fill After $1200 per person per plan year Co-pay Brand - $15, Generic -$0 Formulary applies Mandatory Generic required
same as above	up to 90 day supply/2 Co-pays	same as above
$100 per day/$300 maximum Substance Abuse/limited to 20 days	$100 per day/$300 max./Mental Health Plan covers 80% for Substance Abuse	$100 per day/$300 max.
$25 Co-pay Substance Abuse/limited to 30 days	$25 Co-pay for Mental Health 80% Substance Abuse	$25 Co-pay
Plan covers 70% of fee schedule $1000 deductible Plan covers 70% of fee schedule $1000 deductible; wellness not covered	Emergencies are covered No out-of-network benefit[2] Emergencies are covered No out-of-network benefit[2]	Life & Limb Emergencies are Covered No out-of-network benefits Life & Limb Emergencies are Covered No out-of-network benefits

Information on this chart is intended for general comparison only.
For complete information about any of the plans, please refer to the appropriate plan document.

Who's Eligible?

You may enroll in the Office of Group Benefits program if you are a **full-time employee** (as defined by a Participant Employer in accordance with state law) **of a participating agency or school board.** No person working on a temporary appointment will be considered an employee.

DEPENDENTS:

The following persons may be enrolled as dependents:

A. Your legal spouse.

B. Your never married children under 21 years of age who are dependent upon you for support.

C. Your never married children, age 21 or older, but under 24 years of age, who are enrolled and attending classes as full-time students and are dependent upon you for support. (A full-time student is one enrolled in an accredited university, vocational, technical, trade school, institute, or a secondary school, for the number of hours or courses considered to be full-time attendance by that school or institution.) You must furnish a letter from the registrar as proof of full-time student status of a dependent child each semester/quarter.

The term "children" includes the following:

(1) Natural or legally adopted children of you or your spouse, dependent upon you for support.

(2) Children who have been placed with your family for adoption by agency adoption contract or by irrevocable act of surrender for private adoption, who are living in your household and/or will be, included as dependents on your federal income tax return for the current or next tax year.

(3) Other children for whom you have been granted guardianship or legal custody, who live in your household and/or will be, included as dependents on your federal income tax return for the current or next tax year. Legal custody may include provisional custody.

(4) Grandchildren for whom you do not have legal custody or guardianship, who are dependent upon you for support and whose parent is one of your covered dependents.

Reminder for Student Dependents aged 21-23

*You **must** furnish proof of full-time student status of a dependent child within 30 days of start date of each semester/quarter.*

Military Reserve Members:

Certain provisions have been made for military reserve members.

If you are a military active, please consult your Plan Document for specific eligibility criteria and required documentation.

Over-Age Dependents (Continued Coverage)

If a dependent child is incapable of self-sustaining employment by **reason of mental retardation or physical incapacity** and became incapable prior to the termination 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. Also:

- The child has never been married.
- The child must have been a covered dependent prior to reaching age 21.
- An application for continue coverage, together with supporting medical documentation, must be submitted to OGB. (Eligibility Department)

See Plan Document for documentation required to establish eligibility.

Coverage for Retirees

To be eligible for retiree coverage, your coverage must be in effect prior to your retirement date. For those beginning participation or rejoining on or after January 1, 2002, the state subsidy of your premium is based on the number of years you have participated in a Group Benefits Health Plan. This is called vesting, and also applies to dependents who begin coverage after July 1, 2002.

RETIREE VESTING SCHEDULE

Years of Participation	Percentage of State Subsidy
10 years or fewer	19%
More than 10 years, but fewer than 15	38%
15 years or more, but fewer than 20	56%
20 years or more	75%

*The **Vesting Schedule** is the timeline showing the number of years you must participate in a Group Benefits health plan in order to receive a specific premium subsidy from the State.*

Returning to full-time work?

You must let your hiring agency know that you are a retiree returning to work. The agency will notify OGB so that your premiums will continue to be paid correctly.

Do You Have a Pre-Existing Condition (PEC)?

Employees and dependents who apply for coverage are subject to a pre-existing condition limitation.

- Under the pre-existing condition limitation, **no benefits are payable during the first 12 months** of coverage in connection with any disease, illness, accident, or injury diagnosed or treated during the six months immediately prior to the **enrollment date.** Pregnancy is not considered a pre-existing condition.
- You must complete an **enrollment form** within 30 days after acquiring each new dependent (by birth, adoption, marriage, or otherwise). If you fail to do so, your dependent may be subject to the pre-existing condition limitation.
- **You may be exempt** from all or part of the pre-existing condition limitation if you were continuously covered under another health care plan within 63 days prior to the effective date of your coverage in this Program.

Refer to "If You Have Coverage Outside of OGB," page 7 and page 8 regarding rules on credits against the PEC.

> *Remember:*
>
> *You must complete an enrollment form within 30 days after acquiring each new dependent (by birth, adoption, marriage, or otherwise). If you fail to do so, your dependent may be subject to the pre-existing condition limitation.*

Effective Date of Coverage New Hires and Transfers:

The effective date of coverage for new hires and transfers whose employment begins on the first of the month will be the first day of the following month. If employment begins on the second day of the month or later, coverage is effective the first day of the second month following employment. An employee who transfer employment should complete a transfer form within thirty days.

Example:	If Employment Begins: **September 1**	Coverage Begins: **October 1**
	If Employment Begins: **September 2**	Coverage Begins: **November 1**

Overdue Applicants:

The effective date of coverage for overdue applicants whose forms are received prior to the fifteenth of the month will be the first day of the month following the date of receipt by the Program of all required forms. The effective date of coverage for overdue applicants whose forms are received on or after the fifteenth of the month will be the first day of the second month following receipt.

> *Retirees may not obtain coverage as overdue applicants.*

> *"Overdue applicants " are employees who apply for coverage more than 30 days after employment or dependents that are not added within thrity days of eligibility.*

Notice of Right to Continue Group Health Coverage

If You Have Coverage Outside of OGB:
Special Enrollment under HIPAA

Under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline enrollment for yourself or your dependents (including your spouse) because of other coverage, you may in the future be able to enroll yourself and your dependents in this Plan under special enrollment, provided that you request enrollment within 30 days after your other coverage ends.

- To qualify for this "Special Enrollment," HIPAA requires the completion of a waiver of coverage at the time of initial eligibility.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents under Special Enrollment, provided that you request enrollment within 30 days.
- The effective date of coverage for Special Enrollment is the first of the month following the date of receipt by the Program of all required enrollment forms.
- The "Pre-existing condition" limitation applies to Special Enrollment provisions.

COBRA:

This is a name given to a federal law enacted in 1986 requiring that most group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances.

Portability of Prior Coverage — Credit Against PEC Period

When you and your dependents are enrolled, you are subject to a pre-existing condition limitation as explained above.

If you previously had other health care coverage defined as "creditable coverage" under HIPAA, and that other coverage terminated within 63 days of the date of coverage under the Program, your prior health coverage will be credited against the 12 months pre-existing condition exclusion period under the program.

Since July 1, 1996, you are entitled to a certificate that will show evidence of your prior health coverage for the previous two years.

Continuation of Coverage

Coverage for you and/or your dependents generally terminates on the last day of the month that you cease to meet the eligibility guidelines. Coverage may be continued beyond that date in the following instances:

A. **Leave of Absence** – You may continue your coverage during that leave for a period up to, but not exceeding, one year if you have an approved leave of absence.

B. **Family and Medical Leave** – **(FMLA)** You may continue your coverage if you are on approved Family and Medical Leave as provided under federal law.

C. **Surviving Family** – Surviving spouses and/or surviving dependent children of a deceased employee may continue coverage if certain criteria are met. (Refer to Plan Document for details.)

"Portability" refers to your right to take your insurance coverage with you when you leave employment.

Remember: To receive benefits under HIPAA, you must request enrollment within 30 days after your other coverage ends.

For a new dependent, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Non-Network Ancillary Charges: *Although your hospital and physician may have contracts with OGB, they may recommend or use other providers (labs, ER physicians, x-ray companies, etc.) that do not. To receive your maximum benefit, always check with OGB or the specific provider to verify current participation.*

OGB's PPO Program (Preferred Provider Organization)

The PPO option offered to you is administered by OGB. To understand how this Plan compares and contrasts to others you may choose from, please review the quick-reference comparison chart we have provided for you in the front of this booklet.

SCHEDULE OF PPO BENEFITS:

I. Lifetime Maximums

A. All benefits except outpatient prescription drugs:	$1 million per person
B. Outpatient prescription drugs:	$250,000 per person
C. Durable medical equipment: *(included in $1 million Medical Lifetime Maximum)*	$50,000 per person

II. Deductibles

A. Medical/Surgical/other eligible expense:	$500 per person/active $300 per person/retiree per plan year *(family unit maximum — 3 individual deductibles)*
B. Mental Health and Substance Abuse:	$200 per person per plan year (separate from all other deductibles)
C. Emergency Room:	$150 co-pay *(in addition to medical deductible/waived if admitted to hospital through ER)*
D. Hospital In-patient:	$50 per day *(maximum 5 days per admission—waived at PPO hospitals when OGB is primary)*

III. Benefits Payable after Deductibles and co-payments:

A. PPO Services:	90% *(eligible expenses to $10,000 per person per plan year)*
B. Non-PPO services when plan member resides out of state:	90% *(eligible expenses to $10,000 per person per plan year)*
C. Non-PPO services when plan member resides in Louisiana:	70% *(eligible expenses to $10,000 per person per plan year)*
D. Non-PPO when OGB is secondary:	80% *(eligible expenses to $10,000 per person per plan year)*
E. Mental health and substance abuse services:	80% *(eligible expense [MAP only] to $5,000 per person per plan year)*

***** Non-network services are not eligible expenses; therefore, there is no reimbursement. *****

F. Eligible expenses in excess of $10,000 per person, per plan year: 100%

An assignment of benefits means the provider accepts the fee schedule and payment is sent to the provider, if any payment is due.

* Eligible expenses at PPO providers are based on contracted rates. PPO discounts are not eligible expenses and do not apply to the $10,000 stop loss.
* Eligible expenses at Non-PPO providers are based on a fee schedule. Charges that exceed the fee schedule are not covered by this plan. These charges do not apply to the $10,000 stop loss and may be the responsibility of the plan member

For Medicare Primary Retirees

As a retiree covered by Medicare, you have three Medicare options available to you—Medicare A and B, Medicare Part A only or Medicare Part B only.

Medicare — Parts A and B

Benefits Payable:

80/20% of eligible expenses (after $300 deductible)*

Inpatient Deductible:	$50 per day/$250 max**
Prescription Drugs:	50/50 co-pay, maximum to plan member of $50 per prescription; per maximum 34 day supply.
	See page 22 for more information.

Medicare — Part A Only

Benefits Payable:

A-Portion:	80/20% of eligible expenses (after $300 deductible)*
Inpatient Deductible:	$50 per day/$250 max**
B-Portion:	$300 deductible/ 90/10% (in network)
Prescription Drugs:	50/50 co-pay, maximum to plan member of $50 per prescription; per maximum 34 day supply.
	See page 22 for more information

Medicare — Part B Only

Benefits Payable:

A & B Portion:	80/20% of eligible expenses (after $300 deductible)*
Inpatient Deductible:	$50 per day/$250 max**
Prescription Drugs:	50/50 co-pay, maximum to plan member of $50 per prescription; per maximum 34 day supply.
	See page 22 for more information.

*Plan year deductible—$300 per person

**This is per confinement and in addition to the $300 plan year deductible

OGB plan year starts July 1st and ends on June 30th

What is Retiree 100?

Retiree 100 is optional coverage available to retired Plan Members who have **(Medicare A and B)** as their primary insurer.

Normally, Medicare and Group Benefits reimburse a significant percentage of your eligible health care expenses. However, since Medicare reimburses only part of the cost, and Group Benefits allows benefits only on what is left after Medicare pays, you usually have to pay part of the cost as well.

Retiree 100 coverage may provide higher reimbursements for eligible medical expenses (after deductibles are met) by considering the total charges billed by an eligible provider, not just the balance due after Medicare has paid.

Advantage of the Program

The advantage of the Retiree 100 program is additional coverage for members who have extensive hospital bills and/or large amounts of physician charges due to a serious illness, accident, or long-term chronic condition.

Who is Eligible to Enroll?

You are eligible to enroll in Retiree 100 if:

- You are a retired state employee
- You are a member of Group Benefits PPO, EPO or MCO plans
- Medicare is your primary insurer
- You have both parts of Medicare (A and B)

You may also enroll your spouse if:

- You currently cover your spouse as a dependent
- Medicare is your spouse's primary health insurer
- Your spouse has both parts of Medicare (A and B)

Not All Expenses Are Eligible

Retiree 100 coordinates only those expenses considered eligible for reimbursement by both Medicare and Group Benefits.

Expenses not eligible for consideration include:

- **Out-patient Prescription Drugs** – Medicare does not pay for prescription drugs.
- **Benefits Assigned** – When a provider agrees to accept what Medicare allows as full payment. Group Benefits does not pay for any portion of the bill exceeding the Medicare allowable amount.
- **Mental Health/Substance Abuse Expenses**

Premiums

The monthly premium for Retiree 100 is $39.00 per person.

There is no State contribution toward the premium amount; you must pay the entire cost for Retiree 100 coverage. Your monthly premium for Retiree 100 is **in addition** to your monthly Group Benefits premium.

Enrollment

If you are already retired, you may enroll within 30 days after the date you first became eligible for Medicare (A and B). Coverage becomes effective on the first day of the month you became eligible for Medicare.

Also, you may enroll during the Annual Enrollment period held each year, usually in April. The effective date of coverage will be July 1.

If you are an active employee who is eligible for Medicare, you have 30 days from the date you retire to enroll. Coverage becomes effective on the first day of the first full month of retirement.

- Since Retiree 100 does not have a waiting period for pre-existing conditions, you are eligible for benefits the very first day you are covered.
- Enrollment documents are available through your agency and Group Benefits offices.

Option to Cancel at Any Time

You may cancel Retiree 100 coverage at any time by notifying the Group Benefits Eligibility Department in writing. Your letter should include the plan member's name, address, telephone number, and Social Security number. Cancellation becomes effective on the last day of the month in which your notice of cancellation is received by Group Benefits.

If you decide to drop coverage, you may enroll again during any Annual Enrollment period, as long as you continue to meet the eligibility requirements.

How Retiree 100 Works

A. Your provider files your claim with Medicare.

B. You submit your Medicare Explanation of Benefits, itemized bill from your provider with diagnosis and procedure codes, and claim form to us.

C. We calculate your benefits as follows:

1. We determine the eligible amount of the bill that is unpaid after Medicare has paid.
2. We calculate how much Group Benefits would have paid at the 80% coinsurance rate, after deductibles.
3. We subtract the amount from Step 1 from the amount of Step 2 and pay the difference, up to 100% of your eligible health care.

Well Adult Care

This program includes routine physical examination by a physician that may include an influenza vaccination, lab work, and x-rays performed as part of the exam in that physician's office and billed by that physician with wellness procedure and diagnosis codes. All other health services coded with wellness procedures and diagnosis codes are excluded.

This benefit covers up to $200 in expenses, not subject to deductible, for physical examination and related pathology and radiology services.

The examination MUST be performed by a physician and be billed by that physician. Member will get the maximum on their wellness benefit at network providers.

If the patient has used his/her eligible wellness benefit for the time period in which he/she is able to receive benefits, OGB **will deny** any other wellness claims as not eligible.

The patient is responsible for any wellness costs exceeding the allowable benefit of $200.

WELLNESS CARE

These codes are subject to change on an annual basis. Appropriate diagnosis (V70.0) and eligible services for well adult care must be billed.

ADULT WELLNESS

AGES	BENEFIT AMOUNT	TIME FRAME
16-39	$200.00	During a 3 – year period
40-49	$200.00	During a 2 – year period
50 & Over	$200.00	During a 1 – year period

99384 Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures**, new patient**, age 16 – 17.

99385 age 18 – 39
99386 age 40 - 64
99387 age 65 and over
99394 Periodic re-evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures**, established patient**, age 16 – 17 .
99395 age 18 – 39
99396 age 40 – 64
99397 age 65 and over

LABORATORY TESTS

ELIGIBLE SERVICE	DESCRIPTION	ELIGIBLE SERVICE	DESCRIPTION
80050	General health panel	82952	Tolerance test-beyond three specimens
80053	Comprehensive metabolic panel	83718	Lipoprotein, direct measurement; HDL
80061	Lipid panel	84443	Thyroid stimulating hormone
81000	Urinalysis	84478	Triglycerides
81001	Automated with microscopy	85007	Blood count: manuel differential WBC count
81002	Without microscopy	85027	Complete (CBC), automated, (Hgb, Hct, Rbc, Wbc, and platelet count)
81003	Without microscopy, automated	85025	Hemogram and platelet count, automated, and automated complete
82270	Blood, occult: feces screening	82747	RBC
82465	Cholesterol, serum total	82947	Glucose; quantitative
82948	Blood, reagent strip	85610	Prothrombin time
82951	Tolerance test (GTT)	85651	Sedimentation rate, erythrocyte; non-automated

RADIOLOGICAL TESTS

ELIGIBLE SERVICES	DESCRIPTION
71010	Radiologic examination,chest, single view,frontal
71015	Stereo, frontal
71020	Radiologic examination,chest,two views,frontal and lateral
71030	Complete, minimum of four views

INFLUENZA VACCINES

ELIGIBLE SERVICES	DESCRIPTION
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use

PREVENTIVE CARE

ROUTINE PAP SMEARS

AGES	BENEFIT AMOUNT	TIME FRAME
No age limit	Deductible does not apply-Subject to coins and copay.	1 per 12 months

ELIGIBLE SERVICE	DESCRIPTION
88142	Cytopath cer/vag; manual screen
88143	Cytopath Cerv/Vag Thin prep; W
88147	Cytopath Cerv/Vag thin prep; A
88148	Cytopath Cerv/Vag; Auto Screen
88150	Cytopath Slide Cerv/Vag; Manual
88152	Cytopath Slide Cerv/Vag; M
88153	Cytopath Cerv/Vag; Man Scrn-RE
88154	Cytopath Cerv/Vag; Man Scrn-CO
88164	Cytopath Slides-Cerv/Vag; Man
88165	Cytopath Slides-Cerv/Vag; Man
88166	Cytopath Slides- Cerv/Vag; Man
88167	Cytopath Slides-Cerv/Vag; Scrn
88199	Cytopathology Procedures
P3000	Screen Pap by Tech w MD Supv
Q0091	Obtaining Screen Pap Smear

ROUTINE MAMMOGRAMS

AGES	BENEFIT AMOUNT	TIME FRAME
35-39	Deductible does not apply-Subject to co/ins and copay.	1 every 5 years
40-49	Deductible does not apply-Subject to co/ins and copay.	1 every 24 months
50 & Over	Deductible does not apply-Subject to co/ins and copay.	1 every 12 months

ELIGIBLE SERVICE	DESCRIPTION
76090	Mammography; Unilateral
76091	Bilateral
76092	Screening Mammography, bilateral (two view film study of each breast).

**Revenue codes 401-403 are also eligible*

ROUTINE PROSTATE-SPECIFIC ANTIGEN

AGES	BENEFIT AMOUNT	TIME FRAME
50 & Over	Deductible does not apply- subject to coins and copay	1 every 12 months

ELIGIBLE SERVICE	DESCRIPTION
84152	Prostate Specific Antigen; complexed
84153	Prostate Specific Antigen; total
84154	Free

Well Baby and Well Child Benefits

Covered dependent children under age 16 are eligible for wellness benefits, subject to deductible and co-insurance in the PPO plan. Examinations **MUST** be performed by a physician. Benefits include:

Well Baby Care — routine care to a well newborn infant from the date of birth to age one, including:

Newborn facility and professional charges.

All office visits for scheduled immunizations and screenings.

Well Child Care — 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, from age one through age 15, as itemized:

Well Child Diagnosis Code for children 15 and under is V20.2

BABY CARE

AGES	BENEFIT AMOUNT	TIME FRAME
Birth to age 1	Subject to deductible, co ins and copays	All office visits for scheduled immunizations and screening

WELL CHILD CARE

AGES	BENEFIT AMOUNT	TIME FRAME
Age 1 until age 3	Subject to deductible, co ins and copays	3 office visits per year for scheduled immunizations and screening
Age 3 until age 16	Subject to deductible, co ins and copays	1 office visit per year for scheduled immunizations and screening

99381 Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures**, new patient**, under age 1
99382 age 1 – 4
99383 age 5 – 11
99384 age 12 – 15
99391 Periodic re-evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures**, established patient**, under age 1.
99392 age 1 – 4
99393 age 5 – 11
99394 age 12 – 15

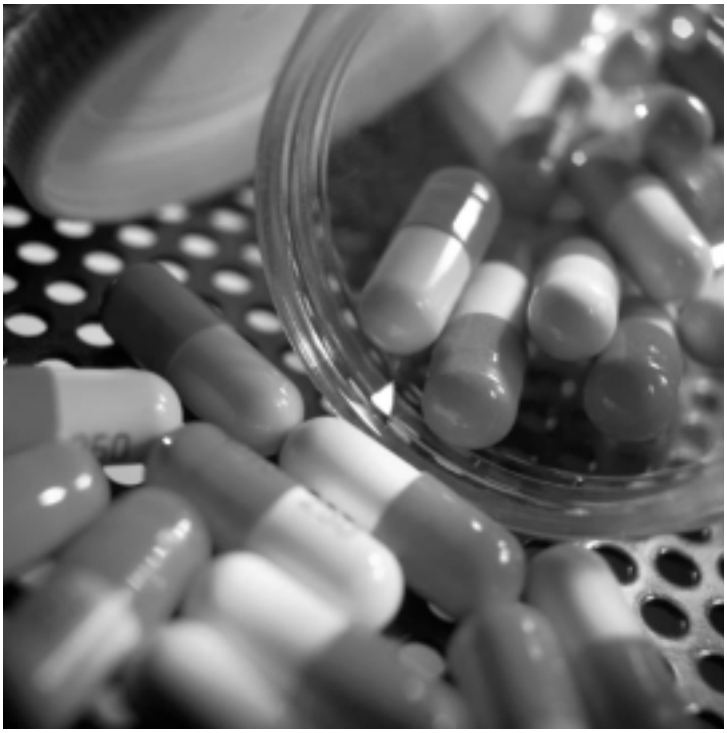
RECOMMENDED IMMUNIZATION SCHEDULE

AGE	IMMUNZATION
Birth	HBV
2 months	DTP.Polio, Hib & HBV
4 months	DTP.Polio, Hib
6 months	DTP.Hib & HBV
15 months	DTP.Polio, MMR & Hib
4-6 years	DTP.Polio & MMR

**Tetanus Diphtheria (TD) every 10 years throughout life*

Examples of Eligible Services

ELIGIBLE SERVICE	DESCRIPTION	ELIGIBLE SERVICE	DESCRIPTION
86580	Skin test; tuberculosis	90705	Measles virus vaccine
86585	Skin test; tuberculosis tine test	90706	Rubella virus vaccine
90389	Tetanus Immune	90707	MMR
90476	Adenovirus vac type 4	90708	Measles and rubella
90585	BCG	90710	MMRV
90645	Hib, HbOC	90712	Poliovirus vaccine
90646	Hib, PRP-D	90713	IPV
90647	Hib, PRP-OMP	90716	Varicella virus vac
90669	Pneumococcal	90718	Tetanus and diphtheria
90680	Rotavirus vac, tetravalent, live, for oral use	90719	Diphtheria toxoid
90700	DtaP	90720	DTP-Hib
90701	DTP	90721	DtaP-Hib
90702	DT	90723	Diphtheria, tetanus
90703	Tetanus toxoid	90733	Meningococcal
90704	Mumps virus vaccine	90748	Hepatitis B and Hemophilus influenza



Services Requiring Pre-Certification

Pre-Admission Certification and Continued Stay Review

Pre-admission Certification (PAC) and Continued Stay Review (CSR) establish the medical necessity and length of inpatient hospital confinement. It is the provider's responsibility to obtain PAC for PPO facilities. If the provider fails to do this, the Plan member cannot be billed for any amount not covered by this Plan.

It is the Plan Member's responsibility to assure that PAC is obtained at non-PPO facilities.
Benefits otherwise payable for services at non-PPO facilities will be reduced by 25% on any confinement for which PAC was not obtained.

For childbirth, PAC is not required for routine vaginal deliveries when the stay is two days or less, or for Cesarean sections when the stay is four days or less. If the mother's stay exceeds or is expected to exceed two days, PAC is required within 24 hours after the delivery or on 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 pre-certification number must be obtained for the baby.

To meet Pre-admission certification requirements and receive benefits:

Pre-admission certification must be requested at least 72 hours prior to admission

Pre-admission certification must be requested within 2 working days following an emergency admission

No benefits will be paid:

- For hospital charges incurred during any confinement for which PAC was requested, but was not certified as medically necessary by the program's utilization review contractor
- For hospital charges incurred during any confinement for any days in excess of the number of days certified through PAC or CSR.

Remember:

Pre-admission certification must be requested at least 72 hours prior to admission.

Pre-admission certification must be requested within 2 working days following an emergency admission.

Outpatient Procedures — Some Require Pre-certification

Physicians and outpatient facilities are required to pre-certify certain outpatient procedures and the related diagnoses. If the provider fails to do this, the Plan member cannot be billed for any amount not covered by Group Benefits.

It is the Plan member's responsibility to assure that outpatient pre-certification is requested on services performed by non-PPO providers. Benefits otherwise payable for services rendered by a non-PPO provider will be reduced by 25 percent for any procedure or therapy on which OPC was not obtained.

To obtain pre-certification, call at 800.432.3432.

Procedures that require pre-certification include:

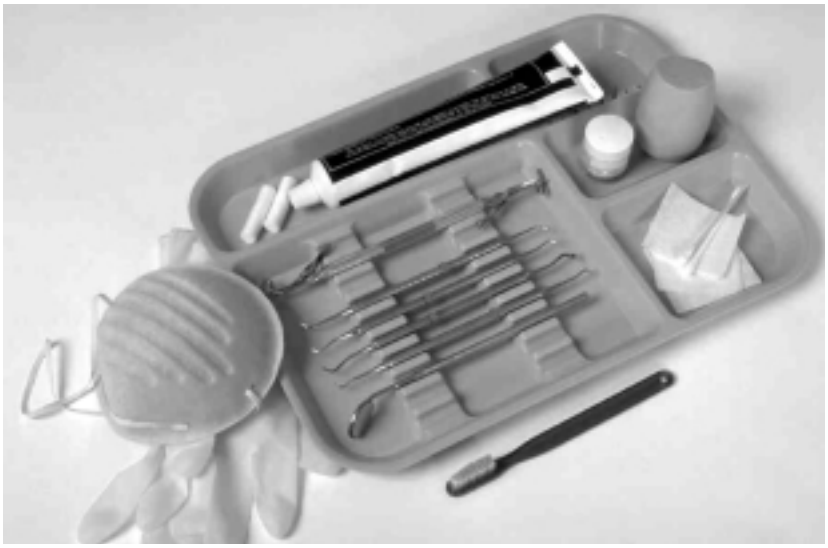
Speech Therapy

Physical Therapy and Occupational Therapy – ONLY when performed in home setting

No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility fee and therapist's fee in connection with outpatient therapies:

Unless outpatient pre-certification is requested at least 72 hours prior to planned date of procedure or therapy.

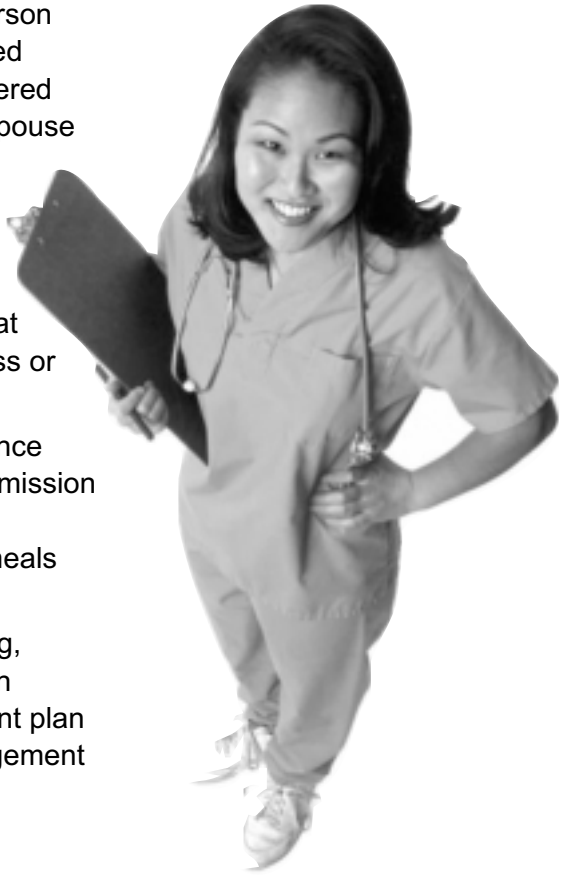
For charges incurred on any listed procedure for which OPC was requested but not certified as medically necessary by the Program's utilization review contractor.



Summary of Exceptions and Exclusions*

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

- Abortion (elective, non-therapeutic)
- Administrative fees, interest, or penalties
- Artificial organ or penile implants, treatment of infertility or complications after the initial diagnosis, including services, drugs, procedures or devices, such as 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
- Charges in excess of the Fee Schedule amount for services, supplies, and treatment
- Convalescent, skilled nursing, sanitarium, custodial, or rest cures
- Cosmetic surgery (unless necessary for the immediate repair of a non-occupational disease, accident, or injury and then only on the specific part of the body directly affected)
- Gender dysphoria (sex change operations) and reverse sterilization
- Genetic testing except when necessary for treatment during pregnancy
- Hair transplants
- Hearing aids (including examination to determine necessity or fitting)*
- Injuries sustained while in an aggressor role and expenses incident to or caused by an attempt at a felony or misdemeanor
- Marriage and family counseling
- Maternity expenses incurred by any person other than a covered employee or a covered employee's legal spouse
- Obesity services, supplies, surgery (including resections for excessive skin or fat following weight loss or pregnancy)
- Personal convenience items, including admission and bedside kits, telephone, guest meals and beds, etc.
- Private duty nursing, except as part of an alternative treatment plan under Case Management
- Radial keratotomy and other procedures for the correction of refractive error.
- Remedial reading and recreational, visual, and behavioral modification therapy, pain rehabilitation control and/or therapy, and dietary or educational instruction for all illnesses, other than diabetes



* Limited Benefits provided for Hearing aids for covered dependents under age 18. See plan document for full details

- 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 Program. 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)
- Charges for services rendered over the telephone from a physician to a covered person
- 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)

**Please refer to your Plan Document for a detailed list of exceptions and exclusions to the Program, or contact your area customer service office for specific questions and information.*

Prescription Drug Program

Toll-Free Pharmacy Line 877.362.3933

OGB contracts with a prescription benefits manager **(PBM)** with a large group of conveniently located network pharmacies and an optional mail service program. Although you may use any pharmacy you wish, there are advantages to selecting a network pharmacy:

low costs

no claims to file

no waiting for reimbursement

The **PBM** will issue your ID card which is to be used for both **medical** and **pharmacy** benefits.

With OGB's Prescription Drug Program,
you have no deductible,
no claims to file,
and no waiting for reimbursement.

What You Pay

Network Pharmacy

Member pays only 50% of drug costs at point of purchase to a maximum co-payment of $50 per prescription dispensed (up to a 34 day supply)

Non-network Pharmacy

Member pays full drug costs at point of purchase.

In-state Purchases

Reimbursement is limited to 50% of the amount payable by the Plan at a network pharmacy.

Out-of-state Purchases

Reimbursement is limited to 80% of the amount payable by the Plan at a network pharmacy.

You may pay more when you use a non-participating pharmacy because fees have been negotiated with network pharmacies.

Co-pay after out-of-pocket is reached

Once your $1200 out-of-pocket in prescription drug purchases is met, you pay only $15 for brand names and nothing for generics.

Extended Supplies on Prescriptions:

For **refills** made within 120 days of the previous fill, you may obtain a 102-day supply of medications at one time if:

1) Your doctor prescribes it, AND
2) If 75% of the amount previously dispensed has been used.
3) Reimbursement is limited to a maximum 34- day supply on the first fill and a maximum 102- day supply on refills. Mail service is also available. Call 877.362.3933 for information.

Remember, prescriptions are limited to the dispensing amount prescribed.

1 to 34 day supply - pay only 50% to a maximum of $50

35 to 68 day supply - pay only 50% to a maximum of $100

69 to 102 day supply - pay only 50% to a maximum of $150

After the out-of-pocket maximum has been met, you pay the following for brand drugs:

1 to 34 day supply - pay only $15

35 to 68 day supply - pay only $30

69 to 102 day supply - pay only $45

How to Use the Retail Pharmacy Program

At Participating Pharmacies:

Present your ID card to the network pharmacy each time you purchase a prescription drug. The pharmacist will use a computerized system to confirm your eligibility for benefits and determine the amount of your co-pay.

At Non-Participating Pharmacies:

Pay the full amount of the prescription at the time of purchase and obtain a prescription drug receipt. Please note that you may pay more when you use a non-participating pharmacy, because fees have been negotiated with network pharmacies.

To obtain reimbursement, you must submit a claim form. Fill out a prescription drug claim form, attach the receipt(s), and mail to the address shown on the claim form. To obtain forms, call 877.362.3933.

Mail service is also available. Call 877.362.3933 for information.

Separate Lifetime Maximum On Prescription Drugs

You have a $250,000 lifetime maximum on your prescription drugs. This lifetime maximum is per person and is in addition to and separate from the current medical lifetime maximum.

For assistance in finding a network pharmacy near you, contact the toll-free pharmacy line at 877.362.3933.

866.492.7143

Accessing Your Benefits

OGB contracts with Mental Health & Substance Abuse (MH/SA) Benefits Program. You and your covered family members can get care by calling 866.492.7143.

When you call, a customer service representative or care manager will help you select a network provider who is convenient to your home or workplace, and will provide an authorization for your treatment. If you need immediate assistance, clinical staff is available 24 hours a day to assist you with finding a provider and obtaining authorization for services.

Your Mental Health & Substance Abuse Benefits include a range of services. When authorized, these services may include:

* Inpatient care
* Intensive outpatient programs
* Partial day treatment
* Detoxification and substance abuse treatment
* Psychiatrist evaluation and office visits
* Outpatient treatment with psychologists, licensed professional counselors, and licensed clinical social workers

In Case of an Emergency

Clinicians are available 24 hours a day to help you in a serious situation. If the situation is life threatening and you believe inpatient services are needed, call 911 or go to the nearest emergency room.

You, your doctor, or family member must call 866.492.7143 within 24 hours to receive authorization for services.

After emergency stabilization, the care manager will assist if needed in arranging for a transfer to an in-network facility. Non-emergency MH/SA problems treated in the emergency room will not be eligible for reimbursement.

Deductibles

$200 per member per plan year. This is separate from the Comprehensive Medical Benefits deductible, and applies to all inpatient and outpatient services including ADD and ADHD.

$50 per day inpatient deductible with a maximum of $250 (5 days) per admission.

Co-Insurance

After deductibles, the member pays 20% of the first $5000 in eligible expenses, with a plan year maximum out-of pocket expense per member of $1000.

Pre-authorization Requirements

The member must obtain Pre-authorization for all services (including diagnostic and consultative services such as psychological testing, diagnosis, and treatment of ADHD, lab, MRI, etc).

All services must meet medical necessity criteria to be eligible for reimbursement.

The member must see a network provider in order to be eligible for benefits.

Call 866.492.7143 for assistance with selecting a network provider.

Limitations

Outpatient visits are limited to medically necessary services not to exceed 52 visits per plan year.

Inpatient days are limited to medically necessary services not to exceed 45 inpatient days per plan year.

Benefits are limited to services provided by in-network providers and facilities only.

Emergency services are reimbursed if, after review, presentation is determined to be life-threatening, resulting in admission to Inpatient, Partial Hospital, or Intensive Outpatient level of care.

Your Right to Appeal

If you or your provider disagrees with a clinical determination, you have the right to appeal. Appeal requests can be made by calling 866.492.7143.

Important Guidelines

You MUST call to obtain pre-authorization BEFORE you receive Mental Health/Substance Abuse treatment. This includes diagnostic services such as psychological testing, lab, MRI, etc and diagnosis/treatment of ADD and ADHD. If you do not receive pre-authorization, you will not be eligible to use your OGB MH/SA benefits

You MUST receive care from a network provider or facility. Out of network authorizations will only be issued when there are no network providers or facilities available in your area.

By following these guidelines, you will help us ensure that you get care quickly and from a provider whose credentials and experience have been thoroughly reviewed and approved.

Pre-authorization before you receive these services is required. Call 866.492.7143 within 24 hours of seeing a physician to receive authorization for these services.

You must receive care from a network provider or facility. Assistance is available 24 hours a day to help you find a provider and obtain authorization for services.

Retirees with Medicare as their primary insurer are required to pre-authorize all inpatient and outpatient treatment for mental health/substance abuse.

Would you like to save money on your taxes?

You can do just that by enrolling in one or more of the three Flexible Benefits Plan Options.

- **Option 1:** Join the Premium Conversion Option and have your eligible insurance payroll deductions taken before the calculation of taxes.
- **Option 2:** Join the Dependent Care Flexible Spending Account Option and set aside money from your paycheck for dependent care expenses before the calculation of taxes.
- **Option 3:** Join the Health Care Flexible Spending Account Option and set aside money from your paycheck for out-of-pocket medical expenses before the calculation of taxes.

The Flexible Benefits Plan Annual Enrollment Period is April 1, 2005 through June 20, 2005.

Who is Eligible?

Active, full-time employees as defined by employers in the following payroll systems:

- Louisiana Community and Technical College System
- Louisiana Department of Transportation and Development
- Louisiana Division of Administration – ISIS/HR Paid
- Louisiana Housing Finance Agency
- Louisiana Senate Accounting Office
- Louisiana Supreme Court
- State Board of Certified Public Accountants of Louisiana
- State Board of Wholesale Drug Distributors
- University of Louisiana at Monroe

Rehired Retirees who are employed as active, full-time employees are eligible for all three options. However, Rehired Retirees **can not** have their Office of Group Benefits' health and life premiums under the Premium Conversion Option.

New hires from private industry are eligible to enroll within thirty (30) days of their hire date in the Premium Conversion Option and the Dependent Care Flexible Spending Account Option.

Enrollment in the Health Care Flexible Spending Account Option is limited to active, full-time employees with a minimum of one year of continuous employment prior to **July 1, 2005** and who enrolls during the 2005 Annual Enrollment Period. **New hires from a public agency** who were participating in a Health Care Flexible Spending Account with their prior public employer is eligible to enroll in the Health Care Flexible Spending Account within thirty (30) days of their hire date for the remainder of the Flex Plan Year.

Enrolling in the Premium Conversion Option!

Eligible employees who want their eligible insurance payroll deductions taken before the calculation of taxes need to complete a "State of Louisiana Flexible Benefits Premium Conversion Enrollment/Stop" form. This form is available at your human resource/payroll department or you can down load the form off of OGB's website. You need to turn in the completed form to your human resource/payroll department.

The Internal Revenue Service does not allow insurance products with cash value or a return of premium riders to be included in the Premium Conversion Option. The following is a list of insurance companies and their eligible insurance products.

OFFICE OF GROUP BENEFITS
OGB PPO Health Plan
FARA MCO Health Plan
HUMANA HMO Health Plan
UNITED HEALTH EPO Health Plan
VANTAGE HMO Health Plan
PRUDENTIAL Basic and Basic Plus
Supplemental Term Life (Employee only)

AMERICAN PUBLIC LIFE INSURANCE COMPANY
Cancer
Dental

CONSECO HEALTH INSURANCE COMPANY
Accident
Cancer
Heart Care

LIFE INVESTORS INSURANCE COMPANY
Cancer
Heart

STARMOUNT LIFE INSURNACE COMPANY
Preferred Dental

AMERICAN FAMILY LIFE ASSURANCE COMPANY (AFLAC)
Cancer
Hospital Indemnity
Intensive Care

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Cancer

COLONIAL LIFE & ACCIDENT COMPANY
Cancer
Hospital Indemnity
Intensive Care

GUARANTY ASSURANCE COMPANY
DINA Preferred (Dental)

GUARANTY INCOME LIFE INSURANCE COMPANY
Q-DENT Plan (Dental)

MS OF A DENT-ALL PLAN, Inc.
Dental/Eye/Rx

NOTE: There is no Administrative Fee for participating in the Premium Conversion Option. Once you enroll in this option, you will automatically continue in it from one year to the next year.
Your eligible insurance payroll deductions are for the full 12 months of the Flex plan year (July 1, 2005 to June 30, 2006). Changes to your deduction can only be made when you experience an IRS qualified event.

Enrolling in the Dependent Care Flexible Spending Account Option!

Do you earn more than $25,000 of annual income? If you do, then the Dependent Care Flexible Spending Account Option is for you.

Important Information to Remember:

- ✓ Your enrollment is for the full twelve months of the Flex Plan Year (July 1, 2005 through June 30, 2006) and changes can only be made when you experience an IRS qualified event.

- ✓ When figuring how much to put into the account, make sure you put in only what you know is going to be your dependent care expenses for the twelve months. Any balance in the account after the end of the twelve months will be forfeited and will not be returned to you. This is because of the IRS "Use it or Lose it" rule.

- ✓ **NOTE:** Employees who participate in the Dependent Care Flexible Spending Account Option are required to pay an Administrative Fee of $2.50 per month.

- ✓ The minimum annual amount is $250.

- ✓ The maximum amount for married tax filing jointly is $5,000.

- ✓ The maximum for single tax filing head of household is $5,000

- ✓ The maximum for married tax filing incapable spouse is $3,000.

- ✓ The maximum for married tax separated is $2,500.

- ✓ You have to re-enroll every year during Flex Plan Annual Enrollment period.

Eligible employees who want to set aside money for dependent care expenses out of your paycheck before taxes are calculated need to complete a "State of Louisiana Flexible Spending Accounts Enrollment" form. This form is available at your human resource/payroll department or you can down load the form off of OGB's website. You need to turn in the completed form to your human resource/payroll department.

Once your payroll department enters your Dependent Care FSA information into their system, then they are to fax a copy of your enrollment form to 1 Point Solutions at their toll-free fax number: 866-254-1927.

To make this option as convenient as possible, 1 Point Solutions, OGB's flexible spending accounts manager, offers a Recurring Expense Service. This service pre-certifies your regularly recurring dependent care expense so that you never have to keep a receipt, complete a claim form or swipe your flexible spending card.

When you need information on your account, you can call 1 Point Solutions Customer Service department at toll-free phone number: 1-866-602-1900 or access your account through their website at: www.1pointsolutions.com

Enrolling in the Health Care Flexible Spending Account Option!

Do you have a lot of out-of-pocket medical expenses? Do you or your children have dental needs in the upcoming year? If you do, then the Health Care Flexible Spending Account Option is for you.

Important Information to Remember:

- ✓ Your enrollment is for the full twelve months of the Flex Plan Year (July 1, 2005 through June 30, 2006) and changes can only be made when you experience an IRS qualified event.
- ✓ When figuring how much to put in the account, make sure that you put in only what you know is going to your out-of-pocket medical expenses for the twelve months. Any balance in the account after the end of the twelve months will be forfeited and will not be returned to you. This is because of the IRS "Use it or Lose it" rule.
- ✓ **NOTE:** Employees who participate in the Health Care Flexible Spending Account Option are required to pay an Administrative Fee of $2.50 per month.
- ✓ You have to re-enroll every year during Flex Plan Annual Enrollment period.
- ✓ The maximum annual amount is $5,000. The minimum annual amount is $600.

Enrollment in the Health Care Flexible Spending Account Option is limited to active, full-time employees with a minimum of one year of continuous employment prior to July 1, 2005 and who enrolls during the 2005 Annual Enrollment Period. **New hires from a public agency** who was participating in a Health Care Flexible Spending Account with their prior public employer is eligible to enroll in the Health Care Flexible Spending Account within thirty (30) days of their hire date for the remainder of that Flex Plan Year.

Eligible employees who want to set aside money for out-of-pocket expenses out of your paycheck before taxes are calculated need to complete a "State of Louisiana Flexible Spending Accounts Enrollment" form. This form is available at your human resource/payroll department or you can down load the form off of OGB's website. You need to turn in the completed form to your human resource/payroll department.

Once your payroll department enters your Health Care FSA information into their system, then they are to fax a copy of your enrollment form to 1 Point Solutions at their toll-free fax number: 866-254-1927.

You can have immediate access to your Flexible Spending Account dollars with the 1Point Solutions card. Present the card anywhere MasterCard is accepted as payment for any of your eligible out-of-pocket medical expenses and the amount is automatically deducted from your account.

When you need information on your account, you can call 1 Point Solutions Customer Service Department at toll-free phone number: 1-866-602-1900 or access your account through their website at: www.1pointsolutions.com

Value Added Services

As an OGB member, you are eligible to access valued added services to reduce your dental and vision expenses from 15-70%.

- There are no waiting periods, no lifetime/annual maximums, no exclusions, and no pre-authorization required.
- In order to receive benefits, you must choose a participating Preferred Provider.
- Present your Office of Group Benefits health plan card at the time of your visit. The provider will verify your eligibility, and the discounted fees will be calculated automatically (you do not file claim forms).
- Providers and benefits are subject to change. Verify benefits with your provider's office prior to scheduling your visit.

No out-of-network benefits apply to this plan, so seek network providers only.

Dental Plan

You may select any provider listed on the prefered provider network. Verify participation prior to each visit. There are no limits on the number of visits to your dentist. Pre-existing conditions are covered.

Vision Plan

Valued added services may reduce your optical expenses 15-50% on everything from eyeglasses to LASIK surgery.

The OGB benefits now include discounts for dental and vision services, as long as you work with in-network providers.

Life Insurance

Life Insurance

Prudential Insurance Company of America underwrites the life insurance coverage offered through OGB. The State pays half of the life insurance premium for the covered employee and/or retiree.

The two plans of life insurance available, along with the corresponding amounts of dependent life insurance offered under each plan are noted below:

Basic Plan

Option I:

Employee: $5,000
Spouse: $1,000
Each Child: $500

Dependent Life: Employee pays $0.90/month

Option II:

Employee: $5,000
Spouse: $2,000
Each Child: $1,000

Dependent Life: Employee pays $1.80 month

Basic Plus Supplemental Plan

Option I:

Employee: Schedule to max. of $50,00
Amount based on employee's annual salary
Spouse: $2,000
Each Child: $1,000

Dependent life : Employee pays $1.80/month

Option II:

Employee: Schedule to max. of $50,000
Amount based on employee's annual salary
Spouse: $4,000
Each Child: $2,000

Dependent life: Employee pays $3.60/month

Important Notes:

Newly hired employees who enroll within 30 days of employment are eligible for life insurance without proving evidence of insurability.

Those enrolling in the life insurance plan after 30 days will be required to supply evidence of insurability to Prudential.

Plan Members currently enrolled who wish to add dependent life on a spouse can do so by proving evidence of insurability. Eligible dependent children may be added without providing **evidence of insurability to Prudential.**

Employee pays 100% of dependent life premium.

Please complete an address change document at your agency benefits office anytime your residence changes.

Accidental Death And Dismemberment
Table Of Losses

Accidental Loss:	Benefit	Accidental Loss:	Benefit
Life	100%	Both hands or both feet	100%
One hand/one foot	100%	Sight in both eyes	100%
One hand/ sight in one eye	100%	One foot/ sight in one eye	100%
Speech/hearing in both ear	100%	Quadriplegia	100%
Paraplegia	75%	One hand	50%
One foot	50%	Sight in one eye	50%
Hemiplegia	50%	Speech	50%
Hearing in both ears	50%	Thumb & index finger/same hand	50%

Who's Eligible
Basic and Basic Plus Supplemental Plans

- Full Time Employees
- Eligible Retirees

Dependent Life

- Covered employee's legal spouse.
- Never married children, under 21 years of age.
- Never married children, 21 years of age to 24 years of age, who are enrolled and attending classes as full-time students and are dependent on the employee for support.

Continued Coverage for Dependent Children

We will continue coverage beyond the termination age for dependent children for a dependent child who is not capable of self-support due to physical handicap or mental retardation. Coverage for such dependent child continues while he remains incapacitated and your coverage stays in force.

Plan Changes at Ages 65 and 70

Members enrolled for life insurance coverage will automatically have 25% reduced coverage on July 1 following their 65th birthday. Another automatic 25% reduction in coverage will take effect on July 1 following their 70th birthday. Premium rates will be reduced accordingly.

A certified copy of the Death Certificate is required before life insurance benefits can be paid.

Portability

Terminated employees may take advantage of the portability provision and continue coverage at group rates. Such coverage will be at a higher rate, and the state will not contribute any portion of the premium. Prudential will determine premium rates. You do not need to submit an evidence of insurability form to continue coverage. Apply for portability through the plan member's agency. Prudential Insurance Company of America must receive the application no later than 31 days from the date employment terminates.

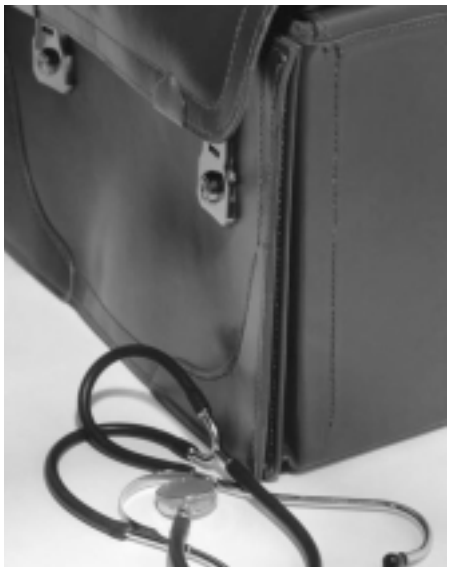
You may be eligible for preferred group rates. You must complete an evidence of insurability form and submit it to Prudential to find out if you are eligible for preferred rates.

Accidental Death and Dismemberment Benefits

Coverage for Accidental Death and Dismemberment benefits automatically terminates on July 1 following the covered person's 70th birthday, if retired. If the plan member is still actively employed at age 70, coverage terminates at midnight on the last day of the month in which retirement occurs.

Death Notification

Please notify the plan member's agency (or former agency, if retired) when a plan member or covered dependent dies. A certified copy of the Death Certificate must be provided to the Plan member's agency.



Life Insurance Plans and Schedules

Basic and Supplemental Life Insurance Schedule

For Active and Retired Employees under Age 65

Schedule 1 effective July 1, 2001
Includes Accidental Death & Dismemberment (AD&D)*

Basic Life: Basic and Supplemental Life:

Annual Earnings**	Maximum Insurance	Total Premium With AD&D***	Employee Share
	$ 5,000	$ 4.60	$ 2.30
2,000.01 – 2,666.66	6,000	5.52	2.76
2,666.67 – 3,333.33	7,000	6.44	3.22
3,333.34 – 4,000.00	8,000	7.36	3.68
4,000.01 – 4,666.66	9,000	8.28	4.14
4,666.67 – 5,333.33	10,000	9.20	4.60
5,333.34 – 6,000.00	11,000	10.12	5.06
6,000.01 – 6,666.66	12,000	11.04	5.52
6,666.67 – 7,333.33	13,000	11.96	5.98
7,333.34 – 8,000.00	14,000	12.88	6.44
8,000.01 – 8,666.66	15,000	13.80	6.90
8,666.67 – 9,333.33	16,000	14.72	7.36
9,333.34 – 10,000.00	17,000	15.64	7.82
10,000.01 – 10,666.66	18,000	16.56	8.28
10,666.67 – 11,333.33	19,000	17.48	8.74
11,333.34 – 13,333.33	20,000	18.40	9.20
13,333.34 – 14,000.00	21,000	19.32	9.66
14,000.01 – 14,666.66	22,000	20.24	10.12
14,666.67 – 15,333.33	23,000	21.16	10.58
15,333.34 – 16,000.00	24,000	22.08	11.04
16,000.01 – 16,666.66	25,000	23.00	11.50
16,666.67 – 17,333.33	26,000	23.92	11.96
17,333.34 – 18,000.00	27,000	24.84	12.42
18,000.01 – 18,666.66	28,000	25.76	12.88
18,666.67 – 19,333.33	29,000	26.68	13.34
19,333.34 – 20,000.00	30,000	27.60	13.80
20,000.01 – 20,666.66	31,000	28.52	14.26
20,666.67 – 21,333.33	32,000	29.44	14.72
21,333.34 – 22,000.00	33,000	30.36	15.18
22,000.01 – 22,666.66	34,000	31.28	15.64
22,666.67 – 23,333.33	35,000	32.20	16.10
23,333.34 – 24,000.00	36,000	33.12	16.56
24,000.01 – 24,666.66	37,000	34.04	17.02
24,666.67 – 25,333.33	38,000	34.96	17.48
25,333.34 – 26,000.00	39,000	35.88	17.94
26,000.01 – 26,666.00	40,000	36.80	18.40
26,666.01 – 27,333.33	41,000	37.72	18.86
27,333.34 – 28,000.00	42,000	38.64	19.32
28,000.01 – 28,666.66	43,000	39.56	19.78
28,666.67 – 29,333.33	44,000	40.48	20.24
29,333.34 – 30,000.00	45,000	41.40	20.70
30,000.01 – 30,666.66	46,000	42.32	21.16
30,666.67 – 31,333.33	47,000	43.24	21.62
31,333.34 – 32,000.00	48,000	44.16	22.08
32,000.01 – 32,666.66	49,000	45.08	22.54
32,666.67 and over	50,000	46.00	23.00

*Accidental Death & Dismemberment benefits are included for all active and retired employees who are under the age of 65.

**Annual Earnings for those academic employees who work fewer than 12 months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees "annual earnings" means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

*** Total includes both state and employee shares of the premium.

For Active and Retired Employees Ages 65 through 69

Schedule 2 effective July 1, 2001
Includes Accidental Death & Dismemberment (AD&D)*

Basic Life:
Basic and Supplemental Life:

Annual Earnings**	Maximum Insurance	Total Premium With AD&D***	Employee Share
	$ 4,000	$ 3.68	$ 1.84
2,000.01 – 2,666.66	5,000	4.60	2.30
2,666.67 – 4000.00	6,000	5.52	2.76
4,000.01 – 4,666.66	7,000	6.44	3.22
4,666.67 – 5,333.33	8,000	7.36	3.68
5,333.34 – 6,666.66	9,000	8.28	4.14
6,666.67 – 7,333.33	10,000	9.20	4.60
7,333.34 – 8,000.00	11,000	10.12	5.06
8,000.01 – 9,333.33	12,000	11.04	5.52
9,333.34 – 10,000.00	13,000	11.96	5.98
10,000.01 – 10,666.66	14,000	12.88	6.44
10,666.67 – 13,333.33	15,000	13.80	6.90
13,333.34 – 14,000.00	16,000	14.72	7.36
14,000.01 – 14,666.66	17,000	15.64	7.82
14,666.67 – 16,000.00	18,000	16.56	8.28
16,000.01 – 16,666.66	19,000	17.48	8.74
16,666.67 – 17,333.33	20,000	18.40	9.20
17,333.34 – 18,666.66	21,000	19.32	9.66
18,666.67 – 19,333.33	22,000	20.24	10.12
19,333.34 – 20,000.00	23,000	21.16	10.58
20,000.01 – 21,333.33	24,000	22.08	11.04
21,333.34 – 22,000.00	25,000	23.00	11.50
22,000.01 – 22,666.66	26,000	23.92	11.96
22,666.67 – 24,000.00	27,000	24.84	12.42
24,000.01 – 24,666.66	28,000	25.76	12.88
24,666.67 – 25,333.33	29,000	26.68	13.34
25,333.34 – 26,666.66	30,000	27.60	13.80
26,666.67 – 27,333.33	31,000	28.52	14.26
27,333.34 – 28,000.00	32,000	29.44	14.72
28,000.01 – 29,333.33	33,000	30.36	15.18
29,333.34 – 30,000.00	34,000	31.28	15.64
30,000.01 – 30,666.66	35,000	32.20	16.10
30,666.67 – 32,000.00	36,000	33.12	16.56
32,000.01 – 32,666.66	37,000	34.04	17.02
32,666.67 and over	38,000	34.96	17.48

*Accidental Death & Dismemberment benefits are included for all active and retired employees who are age 65 through age 69.

**Annual Earnings for those academic employees who work fewer than 12 months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees “annual earnings” means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

*** Total includes both state and employee shares of the premium.

For Active Employees Age 70 and Over

Schedule 3 effective July 1, 2001
Includes Accidental Death & Dismemberment (AD&D)*

	Maximum Insurance	Total Premium With AD&D***	Employee Share
Basic Life: Basic and Supplemental Life:	$ 3,000	$ 2.76	$ 1.38
Annual Earnings**			
2,666.67 – 4000.00	4,000	3.68	1.84
4,000.01 – 5,333.33	5,000	4.60	2.30
5,333.34 – 6,666.66	6,000	5.52	2.76
6,666.67 – 8,000.00	7,000	6.44	3.22
8,000.01 – 9,333.33	8,000	7.36	3.68
9,333.34 – 10,666.66	9,000	8.28	4.14
10,666.67 – 13,333.33	10,000	9.20	4.60
13,333.34 – 14,666.66	11,000	10.12	5.06
14,666.67 – 16,000.00	12,000	11.04	5.52
16,000.01 – 17,333.33	13,000	11.96	5.98
17,333.34 – 18,666.66	14,000	12.88	6.44
18,666.67 – 20,000.00	15,000	13.80	6.90
20,000.01 – 21,333.33	16,000	14.72	7.36
21,333.34 – 22,666.66	17,000	15.64	7.82
22,666.67 – 24,000.00	18,000	16.56	8.28
24,000.01 – 25,333.33	19,000	17.48	8.74
25,333.34 – 26.666.66	20,000	18.40	9.20
26,666.67 – 28,000.00	21,000	19.32	9.66
28,000.01 – 29,333.33	22,000	20.24	10.12
29,333.34 – 30,666.66	23,000	21.16	10.58
30,666.67 – 32,000.00	24,000	22.08	11.04
32,000.01 and over	25,000	23.00	11.50

*Accidental Death & Dismemberment benefits are included for all active employees who are age 70 and over.

**Annual Earnings for those academic employees who work fewer than 12 months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees “annual earnings” means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

*** Total includes both state and employee shares of the premium.

For Retired Employees Age 70 and Over

Schedule 4 effective July 1, 2001
Includes Accidental Death & Dismemberment (AD&D)*

Basic Life: Basic and Supplemental Life:

Annual Earnings**	Maximum Insurance	Total Premium Without AD&D***	Employee Share
	$ 3,000	$ 2.52	$ 1.26
2,666.67 – 4,000.00	4,000	3.36	1.68
4,000.01 – 5,333.33	5,000	4.20	2.10
5,333.34 – 6,666.66	6,000	5.04	2.52
6,666.67 – 8,000.00	7,000	5.88	2.94
8,000.01 – 9,333.33	8,000	6.72	3.36
9,333.34 – 10,666.66	9,000	7.56	3.78
10,666.67 – 13,333.33	10,000	8.40	4.20
13,333.34 – 14,666.66	11,000	9.24	4.62
14,666.67 – 16,000.00	12,000	10.08	5.04
16,000.01 – 17,333.33	13,000	10.92	4.56
17,333.34 – 18,666.66	14,000	11.76	5.88
18,666.67 – 20,000.00	15,000	12.60	6.30
20,000.01 –21,333.33	16,000	13.44	6.72
21,333.34 – 22,666.66	17,000	14.28	7.14
22,666.67 – 24,000.00	18,000	15.12	7.56
24,000.01 – 25,333.33	19,000	15.96	7.98
25,333.34 – 26,666.66	20,000	16.80	8.40
26,666.67 – 28,000.00	21,000	17.64	8.82
28,000.01 – 29,333.33	22,000	18.48	9.24
29,333.34 – 30,666.66	23,000	19.32	9.66
30,666.67 – 32,000.00	24,000	20.16	10.08
32,000.01 and over	25,000	21.00	10.50

*Accidental Death & Dismemberment is dropped on all retired employees on the July 1st following retirement and attainment of the 70th birthday.

**Annual Earnings for those academic employees who work fewer than 12 months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees "annual earnings" means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

*** Total includes both state and employee shares of the premium.

Basic Term Life, AD&D, Basic Supplemental Term Life, and Dependent Term Life coverage are underwritten by the Prudential Insurance Company of America.

This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions, and limitations. A Booklet-Certificate with complete plan information including limitations and exclusions will be provided. If there is a discrepancy between this document and the Group Contract/Booklet-Certificate issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract series 83500.

Important Phone Numbers

For Pre- Admit Certification, Out-Patient Pre-Certification and Continued Stay Review (PAC, OPC and CSR) 800.432.3432

Scheduled admissions/procedures — must pre-certify 72 hours prior to admission/procedure. Emergency admissions — must pre-certify within 2 working days following admission.

PBM (Prescription Benefit Manager) 877.362.3933

Mental Health/Substance Abuse Treatment /Therapy 866.492.7143
Pre-authorize all inpatient and outpatient treatment for mental health/substance abuse.

The numbers listed above may also be found on your ID card.

Area Customer Service Offices
Customer Service offices are located throughout the state to assist you. If you have questions or need assistance, call or visit your area Customer Service office, Monday thru Friday.

Alexandria

900 Murray Street
Room F-100
Alexandria LA 71301
318.487.5731
800.813.1578

Baton Rouge

5825 Florida Blvd.
Baton Rouge LA 70806
225.925.6625
800.272.8451

Lafayette

825 Kaliste Saloom Road
Building II, Suite 101
Lafayette LA 70508
337.262.1357
800.414.6409

Lake Charles

710 W. Prien Lake Road
Suite 109
Lake Charles LA 70601
337.475.8052
800.525.3256

Metairie

3421 N. Causeway Blvd.
Suite 400
Metairie LA 70002
504.838.5136
800.335.6208

Monroe

1400 N. 19th Street
Monroe LA 71201
318.362.3435
800.335.6206

Shreveport

1525 Fairfield Avenue
Room 669
Shreveport LA 71101
318.676.7026
800.813.1574

TDD (Hearing Impaired)

225.925.6770
800.259.6771

Claim Filing Deadline

Claims for services must be filed within one year of the date of service. No benefits are payable for claims received after the deadline. It is not the date of mailing that determines the timeliness; it is the date the claim is received by the program. **(The responsibility for timely filing of a claim is yours even if the provider agrees to file the claim on your behalf.)**

24-Hour Assistance

For ongoing information and assistance, visit the OGB web at **www.groupbenefits.org.**

Check your claim status. Get the latest news about OGB programs and services. Consult our online Frequently Asked Questions section, or submit your own for quick answers to your questions.

It's just another example of how OGB is working hard for you. Log on today.

For Your Notes