LABI Group Proposal

Blue Cross Blue Shield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company
Special note: This information is presented for general information only. It is not a contract, nor is it intended to be construed as a contract. If there is any discrepancy between the information in this brochure and the benefit plan, the benefit plan will prevail. Premium will vary with the level of benefits chosen.

Benefits are based on allowable charges. Allowable charge is defined as the lesser of the billed charge or the amount established or negotiated by Blue Cross and Blue Shield of Louisiana, as the maximum amount allowed for all provider services covered under the terms of the benefit plan. “Blue Chip” refers to LABI group benefit plan #40XX0503. BlueSaver refers to LABI group benefit plan #40XX1326.

Both plans are underwritten by Blue Cross and Blue Shield of Louisiana and are managed by the Louisiana Association of Business and Industry (LABI) and LABI’s plan consultant, Associated Benefit Consultants of LA, Inc. (ABC).
Blue Chip — An Exclusive Program

Blue Chip is a benefit package endorsed by the Louisiana Association of Business and Industry (LABI). Benefits are provided by Blue Cross and Blue Shield of Louisiana. The program, available only to LABI members, is a unique package that provides the broad coverage you need along with several special enhancements.

The plan offers a comprehensive wellness package, a $5 million lifetime maximum, and optional coverage for qualified owners who opt not to purchase Workers’ Compensation. In addition, dental plans are available with 100 percent of allowable charge coverage for routine exams and cleanings for groups with five or more employees.

Blue Chip is simply an outstanding value ... a unique program presented by two organizations dedicated to Louisiana’s future.

An Affordable Investment with a Great Return: Louisiana Association of Business and Industry

Your LABI membership provides you with value above and beyond access to the exclusive Blue Chip program. Your membership and support allow you to impact decisions of the legislative, executive, regulatory and judicial branches of state government on a broad range of issues that affect your bottom line. LABI keeps you informed when your firm’s interests are threatened, provides you with valuable compliance information and gives you access to business decision-making tools. LABI’s efforts on a single issue could save your firm thousands of dollars!

Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is a Louisiana-owned and -operated company committed to the growth and protection of citizens and communities. We support community activities throughout the state and have personal, walk-in service offices near you. We’re proud of the fact that not only are we the oldest health insurance company based in Louisiana, we are also the largest. We continually pay careful attention to maintaining financial stability for our customers by keeping administrative expenses in check and through good operating practices. Our financial strength and security has been recognized by national rating service Standard & Poor’s.
Comprehensive Major Medical Coverage
With Blue Chip, you have your choice of a number of options to customize your group’s coverage with benefits that best fit the needs of your employees. You can select traditional indemnity coverage and its full range of choice, or you can take advantage of our strong provider networks and choose a Preferred Provider Organization (PPO) option, which in turn brings you greater savings in premium costs. With either traditional indemnity or PPO coverage, you get:

- solid coverage for everyday medical expenses
- simplified claims processing
- hospitalization benefits
- coverage backed by the strength of the Cross and Shield
- a lifetime maximum of $5 million in benefits

Preventive and Wellness Care Benefits
The following preventive and wellness care benefits are included with all plans. Coverage is based on 100 percent of the allowable charge and the benefit period deductible does not apply.

- one routine physical exam per benefit period for subscriber, spouse and dependent children age 6 and above ($300 maximum for each member per benefit period)
- routine pediatric exams for dependent children under age 6
- one routine mammogram per benefit period
- one prostate-specific antigen (PSA) test per benefit period
- one routine pelvic exam per benefit period
- one hemoccult (colon) test per benefit period
- one routine Pap smear per benefit period
- tuberculosis skin tests
- immunizations
Physician Office Visit Co-Pay Option
A physician office visit co-pay option of $15, $20, or $25 is available for groups choosing the PPO option with a deductible of $500 or less. Additionally, a co-pay option of $30 is available for groups choosing a $750 deductible and a $40 co-pay option is available for groups choosing a $1,000 deductible. Under the co-pay option, members with PPO coverage who use a preferred provider only pay a flat copayment for eligible office visit services. Blue Cross then pays the remainder of the allowable charge for the eligible medical expense minus the copayment. Please refer to the rate sheet for option(s) quoted.

The copayment applies to the following services when performed in a physician’s office or clinic:

- office visit charges and consultation
- X-rays
- certain laboratory tests
- diagnostic tests
- surgical procedures
- machine tests
- injections
- treatment of mental disorders
- treatment of alcohol and/or drug abuse (if covered)

The physician office visit does not apply to allergy testing, physical therapy, prescription drugs, medical/surgical supplies or preventive and wellness care.

Benefit Period Deductibles
The following deductibles are available: $250, $500, $750, $1,000, $1,500 or $2,000. The deductible applies for the benefit period January 1 through December 31. Other deductible options may be available. Please ask your broker or Blue Cross representative for details.

Each covered family member will have an individual deductible. Once a member reaches his/her deductible for the benefit period, benefits begin based on the coinsurance option chosen below. Once three covered family members reach their deductibles, no other covered member has to satisfy a deductible for the remainder of that benefit period.

Coinsurance Choices
PPO Plans: 90/70, 85/65, 80/60, 70/50 or 60/40
Traditional Plans: 80/20, 70/50 or 50/50
Out-of-Pocket Maximum
Each family member will have an out-of-pocket maximum for the benefit period. When a member’s out-of-pocket expenses for coinsurance reach the selected maximum during any benefit period, covered medical expenses will be paid at 100 percent of the allowable charge for the remainder of that benefit period. Below is a listing of out-of-pocket maximum choices:

- $1,000, after deductible
- $1,500, after deductible
- $2,000, after deductible
- $5,000, after deductible

The $1,000 out-of-pocket maximum is only available with the 80/60, 85/65 and 90/70 PPO coinsurance choices.

For extra protection, there is an aggregate out-of-pocket maximum for family coverage. Please see the Blue Chip illustration for the individual and family out-of-pocket maximums before 100 percent of allowable charge coverage begins.

Inpatient Hospital Deductible
Many groups will have an inpatient hospital deductible in addition to their regular benefit period deductible. This is optional for traditional-style coverage but required for PPO programs. For each inpatient admission, both the benefit period deductible and the inpatient hospital deductible must be satisfied before coinsurance benefits begin. If you choose a traditional-style plan, the inpatient hospital deductible applies for all approved inpatient admissions. For PPO plans, this deductible applies to non-network inpatient admissions only. There are three options available:

- $200 per inpatient admission
- $300 per inpatient admission
- $500 per inpatient admission

Prescription Drug Coverage — Convenience, Simplicity
Prescription drugs are a regular medical expense most people incur. Drug benefits should be simple to access. That’s why the Blue Chip series of PPO and traditional plans offers prescription coverage through a drug copayment program. Benefits are based on allowable charges.

With the prescription drug program, patients can pay a small, fixed copayment at the time of purchase. Just present your ID card to a participating pharmacy along with a valid prescription. No claim forms are necessary, and there’s no waiting on claim checks! Simple copayment-style coverage also applies for prescriptions filled through our state-of-the-art mail-order system.
The Details
Blue Cross and Blue Shield of Louisiana has partnered with Express Scripts, Inc. to manage your prescription drug benefits. As an added cost savings, you can choose a prescription drug deductible option of $100 or $250. Once the deductible is met, the member pays the applicable copayment. All Blue Chip plans include a five-tier copayment structure for prescription drugs. Different copayments apply for each tier. The following chart lists each tier and the copayment options that apply.

<table>
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<tr>
<th>Tier</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
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<td>Retail</td>
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For retail pharmacies, you can receive up to a 30-day supply or the manufacturer’s recommended dosage. When ordering drugs by mail, your copayment covers up to a 90-day supply or the manufacturer’s recommended dosage. Each time you fill a prescription, a new copayment applies. The copayment covers applicable sales taxes. Oral contraceptives are also covered.

Advanced Features
Mail-Order System: Our program’s national mail-order system features the most advanced data processing and dispensing system in the industry. It features rapid at-home prescription delivery, toll-free 24-hour access to registered pharmacists and prescription drug information online. Refills can be ordered by mail, phone or via the Internet at www.express-scripts.com.

Choose Your Pharmacy
Our prescription drug program is part of a nationwide network of pharmacies. We do, however, offer coverage for prescriptions filled at non-participating pharmacies. At these locations, benefits for covered prescriptions usually will be based on the negotiated plan price that would have been charged at a participating pharmacy, less the applicable copayment. Members may have to pay the balance above the allowable charge at non-participating pharmacies. For complete pharmacy network information, call 1-866-781-7533 or visit the Express Scripts website at www.express-scripts.com.

Limitations/Exclusions include, but are not limited to: (see your contract for a complete list)
- drugs used for cosmetic purposes or weight reduction
- investigative drugs
- fertility drugs
BlueSaver: an Investment in Your Health

There’s been quite a buzz lately over HSAs — health savings accounts. An HSA is a tax-deferred savings account to which contributions are made to cover medical and non-medical expenses. To participate in an HSA, members must be covered by a qualified high-deductible health plan and open an HSA with a financial institution.

BlueSaver, our health savings account offering, is a high-deductible health plan that provides the comfort of reliable health care coverage today while members build a financial cushion for their medical and non-medical needs of tomorrow. BlueSaver works with your HSA to act as a savings fund for tax-qualified medical expenses, including those not usually covered by insurance. Funds in the account that are not used for medical expenses can accumulate tax-deferred from year to year until retirement. BlueSaver provides the opportunity to reduce taxes, invest money and reduce out-of-pocket medical expenses.

In addition to sound, affordable health care coverage, BlueSaver offers:

- lifetime protection of $5 million per member
- choice of deductibles
- prescription drug benefits
- preventive and wellness care
- inpatient and outpatient coverage
- wide selection of doctors, hospitals and specialists
- nationwide access to your health benefits

*In order to comply with federal and state regulations, deductibles and out-of-pocket maximums may have to be adjusted annually to reflect changes in the Consumer Price Index.*
**Traditional Coverage:**
Once you meet your individual deductible, covered expenses are paid at 80 percent of the allowable charge. The family deductible, which is an aggregate deductible, may be satisfied by any and all family members. Once the entire family deductible is met, covered expenses are paid for all family members at 80 percent of the allowable charge. The out-of-pocket maximum* includes your deductible and coinsurance. After you meet your out-of-pocket maximum, covered expenses are paid at 100 percent of the allowable charge for that benefit period.

**PPO Coverage:**
After you meet your individual or family deductible, covered expenses are paid at 100 percent of the allowable charge for care received from our PPO network of physicians and hospitals. For other providers, covered expenses will be paid at 80 percent of the allowable charges.

The out-of-pocket maximum* includes your deductible and coinsurance. After you meet your out-of-pocket maximum, covered expenses are paid at 100 percent of the allowable charge for that benefit period.

**Covered services include, but are not limited to:**
- hospital room and board and general nursing services
- use of an operating room, treatment room, recovery room and emergency room
- anesthesia and its administration
- laboratory tests
- oxygen and its administration
- diagnostic services such as radiology, laboratory and pathology services
- telemetry unit for heart patients or an isolation unit
- outpatient medical services rendered in the home, office or other outpatient visits for examination, diagnosis and treatment of an illness or injury, other than pre-operative and post-operative medical visits
- eligible organ, tissue and bone marrow transplants
- drugs and medicines
- intravenous injections and solutions
- transfusion fees and equipment
- medical and surgical supplies
- use of special care units

**Plus These Doctor Expenses:**
- office visits for covered illness or injury
- surgeon’s and assistant surgeon’s fees
- consulting doctor’s fees
- laboratory and X-ray analysis
- anesthesiologist’s fees
- hospital visits by the doctor

* In order to comply with federal and state regulations, deductibles and out-of-pocket maximums may have to be adjusted annually to reflect changes in the Consumer Price Index.
And... 
- blood, blood plasma, blood derivatives and blood processing 
- prescription drugs and medicines for use outside the hospital 
- outpatient private-duty nursing by a registered nurse or licensed practical nurse up to $5,000 per calendar year 
- prosthetic appliances, durable medical equipment and orthotic devices 
- licensed ambulance services for emergency transportation to or from the nearest hospital 
- oral surgery benefits for accidental injury to sound natural teeth, extraction of impacted teeth and other services as listed in your benefit plan 
- certain X-rays and laboratory tests performed in a doctor’s office or clinic 
- a full list of state-mandated benefits

**Prescription Drug Coverage:**
Prescription drugs are common medical expenses incurred by most people. After the deductible is met, the BlueSaver plan provides coverage for generic drugs at 100 percent of the allowable charge and brand-name drugs are covered at 80 percent of the allowable charge. Certain exclusions apply.

**Preventive and Wellness Care**
BlueSaver offers a full list of preventive and wellness care benefits with no deductible:
- one routine Pap smear per benefit period 
- one prostate (PSA) screening and one digital rectal exam per benefit period 
- one mammography exam per benefit period 
- one routine physical exam per benefit period 
- one routine colon (hemoccult) test per benefit period 
- routine pediatric exams for dependent children under age 6 
- one routine pelvic exam per benefit period 
- immunizations 
- tuberculosis skin tests

Benefits are paid at 100 percent of the allowable charge for members with traditional coverage and for PPO members who receive services from a Preferred provider. PPO members who receive services from a non-Preferred provider will be subject to coinsurance.

*Please note that the Dual Choice option is available with both the BlueSaver and Blue Chip PPO products.*
Pregnancy Care
Pregnancy care is usually included in all plans. Groups with fewer than 15 employees on the payroll can exclude pregnancy benefits, if desired. If a group’s number of employees reaches 15 or more, pregnancy care will automatically be added (as required by law). Specified pregnancy complications are covered regardless of whether the pregnancy option is chosen.

Rehabilitative Care Benefits
Rehabilitative care is covered as a standard part of the benefit package. Regular coinsurance, deductible and out-of-pocket limits apply. See benefit plan for a complete list of covered services.

Mental and Nervous/Alcohol and Drug Abuse Treatment
These are standard benefits. Each group must choose one of these two options:

Option 1—Mental and nervous coverage is subject to regular major medical deductible and coinsurance for covered inpatient and outpatient services. Inpatient services are covered up to a maximum of 45 days per benefit period. Outpatient services are covered up to 52 visits per benefit period. Alcohol and drug abuse coverage is subject to regular major medical deductible and coinsurance for covered inpatient and outpatient services. Inpatient services are covered up to a maximum of seven days per benefit period. Outpatient services are covered up to a maximum of 20 visits per benefit period.

or

Option 2 — Coverage for mental and nervous, alcohol and drug abuse is the same as any other illness. Coinsurance payments accrue to the out-of-pocket maximum.

PPO Network
When choosing one of the PPO options, you gain special advantages by choosing care from our PPO provider network. This network, which includes hospitals, physicians, and other providers across the state, is a “preferred provider” system. The PPO network has earned national accreditation from the American Accreditation Health Care Commission/Utilization Review Accreditation Committee, better known as URAC. When receiving covered services from PPO providers, your benefits are paid at a higher coinsurance level. Covered care outside the network is paid at a lower coinsurance level.
Key Physician Network
Regardless of what plan you choose, you will be able to take advantage of our Key Physician network, a special network made up of almost 90 percent of the physicians in the state. These physicians accept what is called an “allowable charge” for covered health care services they provide, and agree not to bill patients for any balance of the fee not covered by the allowable charge. In addition, Key Physicians will routinely file claims for you. Regular usage of this network can add up to substantial savings for your employees.

Member Hospitals
Blue Cross and Blue Shield of Louisiana contracts with most hospitals throughout the state. These member hospitals will routinely file claims for you. Members also have access to a broad network of out-of-state hospitals contracting with other Blue Cross and Blue Shield Plans throughout the country. There may be a 50 percent reduction in benefits for services received from non-member hospitals.

The BlueCard® Program
When our members travel, they take their health care benefits with them — across the country and around the world. The BlueCard® Program, offered exclusively to Blue Cross and Blue Shield members, features a global network of health care providers. More than 85 percent of all doctors and hospitals throughout the United States contract with Blue Cross and Blue Shield Plans. Outside of the United States, our members have access to doctors and hospitals in more than 200 countries. So our members have the peace of mind knowing they’ll find the care they need if they get sick or injured on the road.

It’s easy for members to access a provider outside of their service area:

- They can visit the BlueCard Doctor and Hospital Finder website at www.bcbs.com; or
- Call the BlueCard Access line at 1.800.810.BLUE.

Owner 24-Hour Coverage
For your protection, we also offer coverage for occupational injuries and diseases for qualified company owners. Qualified owners are covered members who own at least 50 percent of the company and can opt not to purchase Workers’ Compensation coverage for themselves. To qualify, each must choose not to elect Workers’ Compensation coverage. Owners who are covered under this option must notify us if they no longer meet the requirements stated above.

This coverage option requires written documentation and home office approval. See representative for details.
Organ, Tissue and Bone Marrow Transplant Benefits
Eligible organ, tissue and bone marrow transplants are covered. Members have access to the Blue Quality Centers for Transplant, a network of major hospitals and research institutions located throughout the country. Patient care is coordinated with Blue Cross and Blue Shield of Louisiana case management, physicians and institutions. Eligible organ, tissue and bone marrow transplants will be covered up to the lifetime maximum, including acquisition expenses. See the organ, tissue and bone marrow transplant section of your benefit plan for complete details and qualifications.

Vision and Hearing Discount Network
Members can take advantage of special discounts on vision and hearing services. Blue Cross and Blue Shield of Louisiana has contracted with certain providers to give members and their immediate families discounts on vision and hearing services. Members simply present their ID card to one of the participating providers and immediately receive significant savings. Since these are discount programs only, there are no claim forms, no deductibles and no waiting for reimbursement! Please note that these services are not eligible for benefits under the benefit plan.
Blue Cross and Blue Shield of Louisiana is strengthened by our Care Management programs that ensure your care is appropriate. Our team of doctors, nurses and in-house pharmacists oversees our members’ care through the following functions:

**Authorization of Elective Admissions**
If you need to be hospitalized for a condition other than an emergency, your admission to the hospital requires “authorization,” which must be obtained before you are admitted. Patients, physicians, hospitals and our Care Management Department all participate in the authorization process that is used to determine whether hospitalization is necessary and an appropriate length of stay. In the case of an emergency admission, authorization must be requested within 48 hours of the admission.

**Concurrent Review**
The process of determining whether continued hospital care is appropriate, also called concurrent review, will be conducted from time to time during a hospital stay. Our Care Management Department works directly with the patient, the hospital and the admitting physician to assess the continued necessity of hospitalization. If a patient chooses to stay in the hospital after it is determined to be unnecessary, he or she may be responsible for all expenses incurred during the remainder of the stay.

**Case Management**
Case Management is a special service performed at the discretion of Blue Cross. Case Management oversees the treatment of unusually complex, difficult or lengthy illness. The Case Management staff, with the member’s acceptance, can develop a long-term treatment plan to achieve the most efficient, effective use of medical resources. The Case Management program at Blue Cross and Blue Shield of Louisiana is accredited by URAC (the American Accreditation HealthCare Commission). This mark of distinction is viewed as a benchmark for quality among managed care organizations and makes us one of the first Blue Cross plans in the nation to receive this accreditation.

**Authorization of Covered Services**
Certain services, drugs and visits to certain providers require authorization from Blue Cross before they can be obtained. The authorization process allows our medical staff to review a procedure or service and determine whether it is in the best interest of the patient. Please see your benefit plan and Schedule of Benefits for a list of procedures, services and supplies that require authorization.
Retrospective Review
A retrospective review may be performed to assess the medical need for services that have already been rendered.

Health and Wellness
Because prevention is key in keeping our members healthy, the Health and Quality Management component of our program sponsors wellness activities such as health events, preventive health screening services and member education. We use systems and decision support tools that identify eligible members for specific health care programs, which are often referred to as Disease Management Programs, such as respiratory health, diabetes and hepatitis C. The programs include identification of and communication with members with these long-term, chronic illnesses. Members receive educational materials and interventions that promote maintenance of their wellness. Members in need of direct nurse intervention are referred to our Case Management program. Other ongoing health education and wellness initiatives include:

- Quarterly member newsletters that feature preventive health services reminders, healthy living articles, healthy recipes and lifestyle articles
- Reminder calls and letters to individual members for screening services
- Active participation in the Louisiana Childhood Immunization Coalition

General Conditions
Eligible Groups
Blue Chip and BlueSaver plan options are available only to companies that are members of the Louisiana Association of Business and Industry. Coverage can, however, be sold to a non-LABI member who agrees to become a member by the time of enrollment.

All groups with two or more employees are eligible to apply for coverage. There are no industry restrictions. Firms that have been in business less than one year are subject to home-office rating and approval. Firms that do not have a current carrier, or are seasonal, also are subject to home-office rating and approval. In some cases, firms with a significant number of employees living outside of Louisiana may not be eligible.

If a firm chooses a contributory plan where employees pay part of the premium, at least 75 percent (60 percent with spouse-elsewhere credit) of its full-time eligible employees must participate. If the employer pays 100 percent of the premium, then 100 percent of the eligible, full-time employees are required to participate. These percentage requirements are for the initial and ongoing enrollment. Other specific conditions that may apply are contained within the group master application or the company’s underwriting guidelines.
Eligible Employees
All full-time employees working a minimum of 30 hours per week and their qualified dependents may apply. Individuals on retainer (such as attorneys, accountants, business consultants and 1099 contract employees) and members of boards of directors are not eligible.

Eligible employees, their eligible spouses and their eligible dependents cannot be individually denied coverage for any reason related to health status. If health question responses are requested by Blue Cross, they will be used for group premium, case management or reinsurance purposes.

The effective date of coverage or benefit change will not be delayed because an employee is not actively at work due to health status.

Exclusions for pre-existing conditions may apply.

Eligible Dependents
Insured employees may cover their spouses. They also may cover their unmarried children and grandchildren as long as they are under 21 years of age (or under 25 if enrolled as a full-time student at an accredited high school, college, university or vocational-technical/trade school). For grandchildren to be eligible they also must reside with and be in legal custody of the employee.

Unmarried children and grandchildren (in legal custody of and residing with the employee) who are mentally or physically disabled also are eligible for coverage. They must be incapable of self-support prior to attaining either of the limiting ages stated above.

See benefit plan for details on other dependents who may qualify.

Group Rates
Initial rates are guaranteed for 12 months. At the end of the rating period, a group’s rates may be adjusted due to factors including:

- demographic changes of the group, including age changes
- claims experience of all groups in the class of business
- a group’s claims experience, health status and duration of coverage
- an overall rise in medical costs
Renewability
All benefit plans are renewable at the employer’s option, except in the cases of:

- non-payment of premium
- fraud or misrepresentation
- non-compliance with plan provisions, including not meeting minimum participation and eligibility requirements
- non-renewal of Louisiana Association of Business and Industry membership
- termination of all employer plans in that class of business (90 days advance notice will be given)

The employer or Blue Cross and Blue Shield of Louisiana may terminate the contract with 60 days advance notice.

Coordination of Benefits
Coordination of benefits will be conducted when a participant has additional group coverage. This provision helps keep premiums low by preventing duplicate payments for the same services.

Health Questions
In groups with two to 19 employees, applicant employees and any eligible dependents must answer all health questions on the employee application form. In groups with 20 or more employees, employees who apply after the group’s initial eligibility period can apply within 30 days prior to the group’s anniversary date and must answer all health questions on the employee application form. These questions will not be used to reject the application.

Prior Group Coverage
When the employer is replacing another group insurer, Blue Cross and Blue Shield of Louisiana adheres to all replacement requirements. Credit will be given for any time served toward a waiting period for pre-existing conditions. This applies to employees listed on the current invoice of the previous insurer.

If an employee declines coverage for himself/herself, spouse or dependent child(ren) because of certain other health insurance coverage, he/she may in the future be able to enroll himself/herself, spouse or dependent child(ren) in this health plan, provided that a complete request for enrollment is received in the home office within 30 days after the other coverage ends (see “Loss of Coverage”). In addition, if an employee gains a new dependent as a result of marriage, birth, adoption or placement for adoption, he/she may be able to enroll himself/herself, spouse and dependent child(ren) in this plan, provided a complete request for enrollment is received in the home office within 30 days after marriage, or within 30 days after birth, adoption or placement of adoption (see “Acquiring a Dependent”).
Loss of Coverage
If an employee, spouse or dependent(s) did not apply for coverage when first eligible because he/she had certain other health coverage, each may be considered a special enrollee if the following applies:

• the employee, spouse or dependent child(ren) declined coverage because of having other health insurance coverage and are otherwise eligible for this coverage AND
• the other coverage terminates due to:
  1. loss of eligibility because of divorce or legal separation, death, termination of employment or reduction in work hours;
  2. termination of employer contributions; or
  3. exhaustion of the total COBRA continuation coverage period.

Acquiring a Dependent
An employee, spouse or dependent child(ren) may be considered a special enrollee if he/she gains a dependent through:

• marriage, provided a complete request for enrollment is received in the home office within 30 days after the date of marriage; or
• birth, adoption, or placement for adoption, provided a complete request for enrollment is received in the home office within 30 days of the qualifying event.

An employee must be covered for the spouse or dependent child(ren) to be covered, and the employee, spouse or dependent child(ren) must otherwise be eligible for coverage.

Late Enrollee
A late enrollee is an eligible employee, spouse or dependent child(ren) who does not enroll for group health insurance coverage:

• when first eligible, and
• does not meet the qualifications of a special enrollee.

An eligible employee must be covered to add a spouse or dependent child(ren).

Late enrollees may apply for group health insurance coverage within 30 days prior to the group’s health insurance policy anniversary date (see “Pre-existing Condition Exclusions”).

Pre-existing Condition Exclusions
A Pre-existing Condition is defined as:

A physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period immediately prior to the eligible member’s enrollment date. Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a pre-existing condition.
Pre-existing Condition Exclusion Period
No benefits will be provided for any charges incurred for any pre-existing conditions subject to the following exclusion periods:

- initial enrollees of a new group policy — 12-month exclusion period (60 days for mental disorders)
- new-hire enrollees if application is received when first eligible — 12-month exclusion period (60 days for mental disorders)
- special enrollees — 12-month exclusion period (60 days for mental disorders)
- late enrollees — 18-month exclusion period (60 days for mental disorders)

Prior Creditable Coverage
Credit will be given for all or part of the pre-existing condition exclusion period if proof of prior creditable coverage is provided. This credit will apply when the other eligible creditable coverage was in force within 65 days prior to the member’s effective date under this coverage.

Pre-existing Condition Exclusions do not apply to:
- newborns, provided a complete request for enrollment is received in the home office within 30 days of the birth;
- adopted children, provided a complete request for enrollment is received in the home office within 30 days of adoption or placement of adoption; or
- pregnancy.

Benefit Plan Limitations and Exclusions
Limitations and exclusions include charges exceeding the allowable charge, investigational treatments, sales tax (excluding covered prescription drugs) or interest, infertility treatments, cosmetic surgery or treatment, weight reduction programs, eye glasses or lenses, contact lenses, correction for refractive errors of the eyes, fertility drugs, treatment of impotence, custodial care, and services that are not medically necessary. Other limitations and exclusions are described in the benefit plan.
Blue Chip presents a full series of PPO and traditional-style programs for your selection. Each of our PPO plans provides two levels of coinsurance. Blue Chip pays the higher coinsurance level when members use preferred providers. Lower coinsurance levels are paid when members use non-preferred providers. Blue Chip’s traditional programs normally pay the same coinsurance level to most providers. See below for a quick outline of each. (This outline does not apply to BlueSaver).

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<th>PLAN</th>
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<th>after member has met deductible requirements and reached out-of-pocket maximum each benefit period.</th>
<th>maximum lifetime benefit per person.</th>
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<tbody>
<tr>
<td><strong>BLUE CHIP PPO 90/70</strong></td>
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<td>after deductible(s) is met for preferred providers, member pays 10%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
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<td>maximum lifetime benefit per person.</td>
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<td></td>
<td></td>
<td>after deductible(s) is met for non-preferred providers, member pays 35%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td><strong>BLUE CHIP PPO 80/60</strong></td>
<td></td>
<td>after deductible(s) is met for preferred providers, member pays 20%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after deductible(s) is met for non-preferred providers, member pays 40%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td><strong>BLUE CHIP PPO 70/50</strong></td>
<td></td>
<td>after deductible(s) is met for preferred providers, member pays 30%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after deductible(s) is met for non-preferred providers, member pays 50%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td><strong>BLUE CHIP PPO 60/40</strong></td>
<td></td>
<td>after deductible(s) is met for preferred providers, member pays 40%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after deductible(s) is met for non-preferred providers, member pays 60%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td><strong>BLUE CHIP TRADITIONAL 80/20</strong></td>
<td></td>
<td>after deductible(s) is met, member pays 20%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td><strong>BLUE CHIP TRADITIONAL 70/30</strong></td>
<td></td>
<td>after deductible(s) is met, member pays 30%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
<tr>
<td><strong>BLUE CHIP TRADITIONAL 50/50</strong></td>
<td></td>
<td>after deductible(s) is met, member pays 50%.</td>
<td>maximum lifetime benefit per person.</td>
<td>maximum lifetime benefit per person.</td>
</tr>
</tbody>
</table>
Southern National Life Insurance Company, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana and was established in 1994 to better serve the insurance needs of our customers. In keeping with the tradition of choices, Southern National Life offers a variety of life insurance, disability, cafeteria and voluntary benefit plans.

Life Insurance/Accidental Death & Dismemberment (AD&D)
Southern National Life offers term life insurance to groups with two or more eligible employees. Eligible employees include all full-time, active employees working 50 hours or more per week. When life coverage is selected, AD&D can be included automatically at the same benefit amount. Groups may choose to insure all employees at the same benefit amount or differentiate benefit amounts based on job levels. A minimum of 75 percent of eligible employees is required for initial and ongoing enrollment. If the employer contribution is 100 percent, then 100 percent of eligible employees must enroll. Plans may be customized depending on group size and type.

Dependent Life
Dependent life coverage is also available for eligible employees and their eligible dependents. Eligible employees include all full-time, active employees working 50 hours or more per week. A minimum of 75 percent of eligible employees with eligible dependents is required for initial and ongoing enrollment. If the employer contribution is 100 percent, then 100 percent of eligible employees and dependents must enroll.

Long-Term Disability (LTD)
Group LTD is available to groups with as few as five eligible employees. Eligible employees include all full-time, active employees working 50 hours or more per week. Coverage is available for most disabilities, including mental and nervous disorders. LTD benefits can be designed to fit the needs of the employer in both costs and coverage. A minimum of 75 percent of eligible employees is required for initial and ongoing enrollment. A minimum of five employees must enroll. If the employer contribution is 100 percent, then 100 percent of eligible employees must enroll.
Short-Term Disability (STD)
This plan offers coverage to eligible employees beginning the first day for accidents or the eighth day for sickness. Eligible employees include all full-time, active employees working 50 hours or more per week. Benefits are payable for non-occupational disabilities up to a maximum of 15 or 26 weeks. Pregnancy coverage is optional. A minimum of 75 percent of eligible employees is required for initial and ongoing enrollment. If the employer contribution is 100 percent, then 100 percent of eligible employees must enroll.

Life Insurance, AD&D and Disability Income
The chart below shows the options available for life, AD&D and disability income insurance. Weekly disability insurance is often referred to as short-term disability, or STD. A number of options are available for STD benefits. Please see the illustration sheets for benefits quoted. Coverage terminates at age 70 or when the employee retires, whichever occurs first.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Life/AD&amp;D Benefit</th>
<th>STD Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Option A</td>
</tr>
<tr>
<td><strong>Plan 1</strong></td>
<td>All employees receive same amount</td>
<td>$10,000 - $50,000 (in $5,000 units)</td>
</tr>
</tbody>
</table>
| **Plan 2** | Partners, officers, proprietors, supervisors and managers
•All other eligible employees | $20,000 | $200 | $300 |
|        | $10,000 | $100 | $200 |
| **Plan 3** | Partners, officers, proprietors
•Supervisors and managers
•All other eligible employees | $30,000 | $300 | $400 |
|        | $20,000 | $200 | $300 |
|        | $10,000 | $100 | $200 |
| **Plan 4** | Partners, officers, proprietors
•Supervisors and managers
•All other eligible employees | $50,000 | $300 | $400 |
|        | $25,000 | $200 | $300 |
|        | $10,000 | $100 | $200 |
| **Plan 5** | All employees | One times annual earnings rounded to the next highest $1,000, subject to a minimum of $10,000 and a maximum of $50,000 | 66-2/3 percent of weekly earnings rounded to the next highest $10 subject to a minimum of $100 and a maximum of $400 |
| **Plan 6** | All employees (must have 16 or more) | Custom plan | 66-2/3 percent of weekly earnings rounded to the next highest $10 subject to a minimum of $100 and a maximum of $400 |
Dependent Life
Dependent life is not required for our life program. There are four options available. Spouse coverage is limited to 50 percent of employee coverage. Dependent life terminates at age 70 or when the employee retires or dies, whichever occurs first.

<table>
<thead>
<tr>
<th>Option</th>
<th>Spouse Benefit</th>
<th>Minor Dependent(s) Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>$2,500</td>
<td>$0 (0 to 14 days) $500 (14 days to 6 months) $2,500 (6 months to end of dependent eligibility)</td>
</tr>
<tr>
<td>Option 2</td>
<td>$5,000</td>
<td>$0 (0 to 14 days) $1,000 (14 days to 6 months) $5,000 (6 months to end of dependent eligibility)</td>
</tr>
<tr>
<td>Option 3</td>
<td>$10,000</td>
<td>$0 (0 to 14 days) $2,000 (14 days to 6 months) $10,000 (6 months to end of dependent eligibility)</td>
</tr>
<tr>
<td>Option 4</td>
<td>Custom plan</td>
<td>Custom plan</td>
</tr>
</tbody>
</table>

This information is presented as general information only. For complete information, please refer to the contract.
Sales Offices:

Alexandria
5417 Jackson Street Extension
Suite B
Alexandria, LA 71303
318.448.1660

Baton Rouge
9100 Bluebonnet Centre
Suite 301
Baton Rouge, LA 70809
225.295.2556

Houma
509 Progressive Boulevard
Houma, LA 70560
985.223.5499

Lafayette
2701 Johnston Street, Suite 200
Lafayette, LA 70503
337.232.7527

Lake Charles
219 W. Prien Lake Road
Lake Charles, LA 70601
337.562.0595

Monroe
3150 Mercedes Drive
Monroe, LA 71201
318.325.1479

New Orleans
3501 North Causeway Boulevard
Suite 600
Metairie, LA 70002
504.832.5800

Shreveport
One Bellemead Centre
6425 Youree Drive, Suite 300
Shreveport, LA 71105
318.795.0573

Customer Service:

Baton Rouge
5525 Reitz Avenue
Baton Rouge, LA 70809-3802
225.293.0625
800.376.7741

BlueCross BlueShield of Louisiana