HMO Point of Service Benefit Plan
For

EAST BATON ROUGE PARISH SCHOOL SYSTEM

Group Benefit Program

Administered by

HMO Louisiana

P.O. Box 98024 • Baton Rouge, Louisiana • 70898-9024
www.bcbsla.com

131HR 01237 0116R

HMO Louisiana

SCHEDULE OF BENEFITS
HMO POINT OF SERVICE
CONTRACT 131HR 01237 0116R

PLAN NAME	**PLAN NUMBER**
East Baton Rouge Parish School System (EBRPSS)	77749 and Departments (Core Plan)
PLAN'S ORIGINAL CONTRACT DATE	**PLAN'S ANNIVERSARY DATE**
January 1, 2006	January 1st
PLAN'S AMENDED CONTRACT DATE	
January 1, 2016	

SCHEDULE OF BENEFITS

Benefit Period	Calendar Year for all providers

	NETWORK	**NON-NETWORK**
Outpatient visits for the following services:	$30.00 per visit	60% - 40%
• Primary Care Physician's office visits for the following Physician and/or Provider specialties: • General Practice • Family Practice • Pediatrics • Internal Medicine • OB/GYN • Licensed Professional Counselor • Masters of Social Work • Physiotherapists • Psychiatrists • Psychologist • Substance Abuse Counselor • Retail Health Clinic • Nurse Practitioner • Osteopath		
• Speech Therapy, Physical Therapy, Occupational Therapy, Cardiac Rehabilitation	80% - 20%	60% - 40%
• Preventive and Wellness Care	100% - 0%	100% - 0% Deductible is not applicable
Outpatient visits for Specialists and Allied Health Professionals office visits for providers not included above	$60.00 per visit	60%-40%
Vision Care Exam, limited to 1 exam in a 24 month period (Optometrist only).	$25.00 per visit	$35.00 per visit
Emergency Medical Services performed in the Emergency Department of a Hospital	80% - 20%	80%-20%

Chiropractic Services	$60.00 per visit	60% - 40% after Deductible; 20 visits each Benefit Period
Ambulance Services	80%-20%	60% - 40%
Ambulatory Surgical Facility and Outpatient Surgical Facility	$100.00 per surgical visit then 80% - 20%	60% - 40%
Inpatient Hospital Admission, all Inpatient Hospital services included (Copayment is in addition to the Deductible Amount and the Deductible Amount is not reduced by the Copayment.)	$600.00 per Admission then 80% - 20%	60% - 40%
Physician's services for Pregnancy Care	$30.00 per pregnancy	60% - 40%
Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices	80% - 20%	60% - 40%
Inpatient and Outpatient services for which a Copayment is not applicable	80% - 20%	60% - 40%
Services for: • Home Health Care, (limited to 75 visits each Benefit Period) • Hospice Care, (limited to 180 days Lifetime Maximum) • Skilled Nursing Facility, (limited to 60 days each Benefit Period)	80% - 20%	60% - 40%
Contraceptive devices and contraceptive drugs (such as IUD, diaphragms, Depo Provera, Lunelle, Implannon implant) are covered when administered in a Physician's office.	100% - 0%	60% - 40%
All other services	80% - 20%	60% - 40%

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

NETWORK AND NON-NETWORK SERVICES

Coinsurance and Inpatient Hospital Copayments for Mental Health, Substance Abuse Benefits are the same as for any other illness.

- The Plan Participant's Coinsurance and the Inpatient Hospital Copayment for Mental Health, Substance Abuse Benefits **is eligible** for satisfying the Out-of-Pocket Amount.

	NETWORK	**NON-NETWORK**
Copayment or Coinsurance for Physician's office visit for Mental Health, Substance Abuse Benefits	$30.00 per visit; then 100% - 0%	60% - 40%

INPATIENT SERVICES	MAXIMUM
Mental Health and Substance Abuse Benefits	Benefits are payable same as any other illness

OUTPATIENT SERVICES	MAXIMUM
Mental Health and Substance Abuse Benefits	Benefits are payable same as any other illness

DEDUCTIBLE/OUT-OF-POCKET AMOUNT

Benefit Period Deductible Amount	$600.00	$1,800.00
The Deductible Amount incurred for each Provider **is not** eligible for satisfying the Deductible amount for the other Provider.		
Out-Of-Pocket Amount The Out-Of-Pocket Amount incurred for each Provider **is not** eligible for satisfying the Out-Of-Pocket Amount for the other Provider.	$4,100.00	$12,300.00
Family Out-Of-Pocket Amount [Aggregate] The Out-Of-Pocket Amount incurred for each Provider **is not** eligible for satisfying the Out-Of-Pocket Amount for the other Provider.	$8,200.00	$24,600.00

ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

- Benefits are subject to applicable Deductible, Coinsurance, Inpatient and Outpatient Copayments.
- Organ, tissue and bone marrow transplants and evaluation for a Plan Participant's suitability for organ, tissue and bone marrow transplants will not be covered unless a Plan Participant obtains written Authorization from the Claims Administrator prior to services being rendered.
- Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

	NETWORK	NON-NETWORK
Organ, Tissue Bone Marrow Transplant Maximum	Same as for any other illness	Not Available
Acquisition Expense Maximum	Same as for any other illness	Not Available

CARE MANAGEMENT

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, the Plan will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary.

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Plan Participant must pay all charges incurred.

If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services.

Authorization of Inpatient and Emergency Admissions:

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress must be made to HMO Louisiana, Inc. by calling [1-800-376-7741].

If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider or Participating Provider is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for any applicable Copayment or his Deductible and Coinsurance percentage.

NOTE: Benefits for Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.

If a Non-Participating Provider fails to obtain a required Authorization, the Plan Participant is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage.

Authorization of Outpatient Services, Including Other Covered Services and Supplies:

If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all services and supplies requiring an Authorization. The Network Provider is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

Additional Network Provider responsibility if Authorization is not requested for Outpatient services and supplies: **30% reduction of the Allowable Charges**.

If a Non-Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all services and supplies requiring an Authorization. The Plan Participant is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage.

Additional Plan Participant responsibility if Authorization is not requested for Outpatient services and supplies furnished by a Non-Network Provider: **30% reduction of the Allowable Charges**.

The following services and supplies require Authorization prior to the services being rendered or supplies being received. Requests for Authorization must be made to HMO Louisiana, Inc. by calling 1-800-376-7741.

- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Durable Medical Equipment (greater than $200.00)
- Home Health Care
- Hospice Care
- Implantable Medical Devices over $2000.00 such as Implantable Defibrillator and Insulin Pump
- Intensive Outpatient Programs
- M.R.I./M.R.A.
- Non-Emergency Ambulance
- Nuclear Cardiology
- Occupational Therapy
- Organ Transplant Evaluation
- Orthotic Devices
- Outpatient surgical procedures not performed in a Physician's office
- Partial Hospitalization Programs
- PET Scans
- Physical Therapy
- Private Duty Nursing
- Prosthetic Appliances (greater than $500.00)
- Residential Treatment Centers

- Speech Therapy
- Sleep Studies
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Vacuum Assisted Wound Closure Therapy
- Medical Nutritional Education/Therapy for Diabetes
- Skilled Nursing Facility Services
- Applied Behavior Analysis

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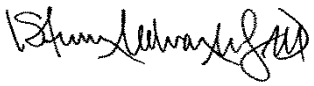
NOTICES

Health care services may be provided to the Plan Participant at a Network health care facility by facility-based physicians who are not in Your health plan's Network. You may be responsible for payment of all or part of the fees for those Out-of-Network services, in addition to applicable amounts due for Copayments, Coinsurance, Deductibles and non-covered services.

Specific information about In-Network and Out-of-Network facility-based physicians can be found at **www.bcbsla.com** or by calling the customer service telephone number on the back of Your identification (ID) card.

Your share of the payment for health care services may be based on the agreement between the Your health plan and Your Provider. Under certain circumstances, this agreement may allow Your Provider to bill You for amounts up to the Provider's regular billed charges.

The Claims Administrator bases the payment of Benefits for the Plan Participant's covered services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom You receive Covered Services.



I. Steven Udvarhelyi, M. D.
President and Chief Executive Officer

HMO Louisiana, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana and an independent licensee of the Blue Cross and Blue Shield Association.

131HR 01237 0116R

EAST BATON ROUGE PARISH SCHOOL SYSTEM (EBRPSS)
HMO LOUISIANA, INC. POINT OF SERVICE
ASO BENEFIT PLAN
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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

The Group is the Plan Sponsor of this Benefit Plan. HMO Louisiana, Inc. provides administrative claims services only and does not assume any financial risk or obligation with respect to Claims liability.

The Group agrees to provide the Benefits specified herein for Employees of the Group and their enrolled Dependents. This Benefit Plan replaces any others previously issued to Plan Participants on the Benefit Plan Date or the amended Benefit Plan Date. This Benefit Plan describes Your Benefits, as well as Your rights and responsibilities under the Plan. We encourage You, the Plan Participant, to read this Benefit Plan carefully.

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

Except for necessary technical terms, common words are used to describe the Benefits provided under this Benefit Plan. "We," "Us" and "Our" means HMO Louisiana, Inc. (HMOLA). "You," "Your," and "Yourself" means the Plan Participant and/or enrolled Dependent. Capitalized words are defined terms in Article II - "Definitions." A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

A. Facts About This HMO Point Of Service Plan

This Benefit Plan describes Point of Service coverage. Plan Participants have an extensive Providers Network available to them - the HMOLA Network. Plan Participants can get care from Providers in their Network, or from Providers who are not in their Network.

Plan Participants can go outside the Network and obtain care from Providers that are not in the HMOLA Network. Plan Participants usually pay a Deductible and Coinsurance when they receive care from Providers outside the Network. Participating Providers are those Providers that have signed contracts to participate in the networks of Blue Cross and Blue Shield of Louisiana or another Blue Cross and Blue Shield Plan. Non-Participating Providers are Providers that do not have a contract to participate in the HMOLA Network or any Blue Cross and Blue Shield network.

Plan Participants who get care from Providers in their Network will pay the least for their care and get the most value from this Benefit Plan. Plan Participants usually pay a Copayment to a Network Provider at the time of service.

B. The HMOLA Provider Network

Plan Participants choose which Providers will render their care. This choice will determine the amount the Plan pays and the amount the Plan Participant pays for Covered Services.

HMO Louisiana, Inc. has put together a Provider Network consisting of a select group of Physicians, Hospitals and other Allied Providers that have contracted with the Claims Administrator to participate as HMOLA Network Providers and render Covered Services to Plan Participants. These Providers are referred to as HMOLA Providers, Network Providers, or In-Network Providers. Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's dental network.

We use the term "Network Benefits" to mean the highest level of Benefits payable under this Benefit Plan when the Plan Participant uses Providers in the HMOLA Network. We use the term "Non-Network Benefits" to mean a lower level of Benefit, if a Plan Participant chooses to go outside the HMOLA Network for care.

To obtain the highest level of Benefits available, the Plan Participant should always verify that a Provider is a current HMOLA Provider before the service is rendered. Plan Participants may review a current paper Provider directory, check on-line at **www.bcbsla.com**, or contact the Claims Administrator's customer service department at the number listed on their ID card.

A Provider's status may change from time to time. Plan Participants should always verify the Network status of a Provider before obtaining services.

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

Additionally, Providers in Your network may be contracted to perform some Covered Services, but may not be contracted in Your network to perform other Covered Services. When a Network Provider performs services that the Network Provider is not contracted with to perform (such as certain high-tech diagnostic or radiology procedures), claims for those services may be denied. The Plan Participant should make sure to check his Provider directory to verify that the services are In-Network when performed by the Provider or at the Provider's location.

We pay a lower level of Benefits when a Plan Participant uses a Provider outside the HMOLA Network. Benefits may also be based on a lower Allowable Charge and/or the application of a penalty. The Plan Participant will usually pay Deductible and Coinsurance instead of a Copayment. Receiving care from a Non-Network Provider will result in higher Out-of-Pocket costs to the Plan Participant. Because Non-Network Providers are able to balance bill Plan Participants up to their full billed charge, Out-of-Pocket costs could be significant. These amounts do not apply to the Out-of-Pocket Maximum. Emergency services performed in the Emergency department of a Hospital, even when the Hospital is not in the HMOLA Network, will be paid at the Network level of Benefits.

It is recommended that the Plan Participant ask Non-Network Providers to explain their billed charges, before care is received outside the Network. Prior to obtaining care outside the Network, You should review the section titled "Sample Illustration of Plan Participant Costs When Using a Non-Participating Hospital."

C. Selecting and Using a Primary Care Physician

This direct access plan allows the Plan Participant to receive care from a Primary Care Physician ("PCP") or from a Specialist Physician. No PCP referral is required prior to accessing care directly from a Specialist in the HMOLA Network.

Plan Participants pay the lowest Physician office visit Copayment when obtaining care from a PCP. PCPs are family practitioners, general practitioners, internists and pediatricians. Each Plan Participant of the family may use a different PCP. PCPs will coordinate health care needs from Consultation to Hospitalization, will direct a Plan Participant to an appropriate Provider when necessary, and will assist in obtaining any required Authorizations.

If one Provider directs a Plan Participant to another Provider, the Plan Participant must make sure that the new Provider is in the HMOLA Network before receiving care. If the new Provider is not in the HMOLA Network, Benefits will be processed at the Non-Network Benefit level and the Allowable Charge applicable to that Provider.

D. Authorizations

Some services and supplies require Authorization from the Claims Administrator before the services are obtained. Your Schedule of Benefits lists the services and supplies that require this advance Authorization. See the Care Management Article of this Benefit Plan for additional information regarding Authorization requirements.

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

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

When the Claims Administrator issues an Authorization but the Plan Participant receives the service from a Non-HMOLA Provider, (a Participating or Non-Participating Provider), Non-Network Benefits will apply, even when the Claims Administrator has Authorized the services as Medically Necessary. A Plan Participant must obtain care from a Provider in the HMOLA Network to receive the highest level of Benefits available under this Plan.

No payment will be made for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless the Claims Administrator Authorizes these services and the services are rendered by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or by a transplant facility in a HMOLA Network, unless otherwise approved by the Claims Administrator in writing. To locate an approved transplant facility, contact the customer service department at the number listed on Your ID card.

E. How the Plan Determines What the Group Pays for Covered Services

1. When a Plan Participant uses Network Providers

   Network Providers are Providers that have signed contracts with the Claims Administrator to participate in the HMO Louisiana, Inc. Provider Network. These Providers have agreed to accept the lesser of billed charges or the amount negotiated as payment in full for Covered Services. This amount is the HMOLA Provider's Allowable Charge. The Plan uses this amount to determine payment for Plan Participant's Covered Services. Plan Participants who use these Network Providers will receive Network Benefits and will pay the amounts shown in the "Network" column on their Schedule of Benefits for these services.

2. When a Plan Participant uses Participating Providers

   Participating Providers have not signed contracts with HMO Louisiana, Inc., but have signed contracts with Our parent company, Blue Cross and Blue Shield of Louisiana, or other Blue Cross and Blue Shield plans to participate in their Provider networks. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services. We use this amount to determine what to pay for the Plan Participant's Covered Services when the Plan Participant uses a Participating Provider. A Plan Participant receiving Covered Services from a Participating Provider will receive a lower level of Benefit than when using a Network Provider, but the Plan Participant will not have to pay the difference between the Allowable Charge and the Provider's billed charge. The Plan Participant will pay the amounts shown in the "Non-network" column on their Schedule of Benefits for these services.

3. When a Plan Participant uses Non-Participating Providers

   Non-Participating Providers do not have a contract for the HMOLA Network, with Blue Cross and Blue Shield of Louisiana, or any another Blue Cross and Blue Shield plan. These Providers are not in Our Networks. The Claims Administrator has no fee arrangements with them. The Claims Administrator establishes an Allowable Charge for Covered Services rendered by Non-Participating Providers. The lesser of the Provider's actual billed charge or the established Allowable Charge to determine what to pay for a Plan Participant's Covered Services when the Plan Participant receives care from a Non-Participating Provider. The Plan Participant will receive a lower level of Benefit because he did not receive care from a Network Provider.

   a. The Plan Participant may pay significant costs when he uses a Non-Participating Provider. This is because the amount that some Providers charge for a Covered Service may be higher than the established Allowable Charge. Also, HMOLA Network and Participating Providers waive the difference between their actual billed charge and their Allowable Charge, while Non-Participating Providers will not. The Plan Participant will pay the amounts shown in the "Non-Network" column on their Schedule of Benefits, and the Provider may balance bill the Plan Participant for all amounts not paid by this Benefit Plan.

Plan Participants are encouraged to ask Non-Participating Providers to explain their billed charges to BEFORE receiving care outside the Network. You should review the sample illustration below in the section titled "Sample Illustration of Plan Participant Costs When Using a Non-Participating Hospital" prior to obtaining care outside the Network. Emergency Medical Services performed in the Emergency department of a Hospital, even when the Hospital is not in the HMOLA Network, will be paid at the Network level of Benefits.

b. The Plan Participant has the right to file an Appeal with the Claims Administrator for consideration of a higher level of Benefits if the Plan Participant received Covered Services from a Non-Participating Provider who was the only Provider available to deliver the Covered Service within a seventy-five (75) mile radius of the Plan Participant's home. To file an Appeal, the Plan Participant must follow the Appeal procedures set forth in this Benefit Plan.

F. Sample Illustration of Plan Participant Costs When Using a Non-Participating Hospital

NOTE: The following example is for illustration purposes only and may not be a true reflection of the Plan Participant's actual Copayments, Deductible and Coinsurance amounts. Please refer to the Schedule of Benefits to determine Benefits.

Example: A Plan Participant has this Point of Service plan with a $150 Hospital Copayment. The Non-Network Benefits are 60% - 40% Coinsurance with a Deductible. Assume the Plan Participant goes to the Hospital, has previously met his Deductible and has obtained the necessary Authorization prior to receiving a non-emergency service. The Provider's billed charge for the Covered Service is $12,000. We negotiated an Allowable Charge of $2,500 with HMOLA Network Providers to render this service. The Allowable Charge of Participating Providers is $3,000 to render this service. There is no negotiated rate with the Non-Participating Provider Hospital.

The Plan Participant receives Covered Services from:	HMOLA Provider Hospital	Participating Provider Hospital	Non-Participating Provider Hospital
Provider's Bill: Allowable Charge:	$12,000 $2,500	$12,000 $3,000	$12,000 $2,500
The Plan pays:	**$2,350** $2,500 allowable -$150 copayment = $2,350	**$1,800** $3,000 allowable charge x 60% Coinsurance = $1,800	**$1,500** $2,500 allowable charge x 60% Coinsurance = $1,500
Plan Participant pays:	**$150** Copayment	**$1,200** 40% Coinsurance x $3,000 allowable charge = $1,200	**$1,000** $2,500 allowable charge x 40% Coinsurance = $1,000
Is Plan Participant billed up to the Provider's billed charge?	NO	NO	YES - $9,500, for a total of:
TOTAL PLAN PARTICIPANT PAYS:	**$150**	**$1,200**	**$10,500**

G. When a Plan Participant Receives Mental Health or Substance Abuse Benefits

The Claims Administrator has contracted contract with an outside company to perform certain administrative services related to Mental Disorders and substance abuse services for the Plan Participants. For help with these Benefits, the Plan Participant should refer to his Schedule of Benefits or his ID Card, or call the Customer Service Department.

H. Obtaining Emergency and Non-Emergency Care Outside Louisiana and Around the World

Plan Participants have access to Emergency and Non-Emergency care outside Louisiana and around the world. The Plan Participant's ID card offers convenient access to Covered Services through Providers throughout the United States and in more than 200 countries worldwide.

In the United States:

Emergencies: Plan Participants receive Network Benefits when covered Emergency Medical Services are provided, regardless of Provider.

Non-Emergencies: Plan Participants receive Non-Network Benefits when covered Non-Emergency Medical Services are rendered outside the Plan Participant's Service Area. Because there is no HMO Louisiana, Inc. Service Area outside Louisiana, Covered Services rendered outside Louisiana are paid at the Non-Network Benefit level. If a Plan Participant obtains these services from a BlueCard Provider, he may only have to pay his Network amount since BlueCard Providers will generally accept the Allowable Charge as payment in full for the service.

Outside the United States:

Emergencies: Plan Participants receive Network Benefits when covered Emergency Medical Services are provided, regardless of Provider.

Non-Emergencies: Plan Participants receive Non-Network Benefits when covered Non-Emergency Medical Services are rendered outside the Plan Participant's Service Area. Because there is no HMO Louisiana, Inc. Service Area outside the United States, Covered Services rendered outside the country are paid at the Non-Network Benefit level. If a Plan Participant obtains these services from a BlueCard Worldwide Provider, he may only have to pay his Network amount since BlueCard Worldwide Providers will generally accept the Allowable Charge as payment in full for the service.

How To Get Care Outside the Service Area:

1. In an Emergency, go directly to the nearest Hospital.

2. Call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest BlueCard doctors and Hospitals (for care within the United States), or for information on BlueCard Worldwide doctors and Hospitals (for care outside the United States). Provider information is also available at **www.bcbsla.com**.

3. Use a BlueCard Nationwide or a BlueCard Worldwide Provider.

4. Present Your ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.

5. The Plan Participant must obtain any required Authorizations from HMO Louisiana, Inc.

I. Assignment of Benefits

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

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

J. Plan Participant Incentives

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

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

K. Customer Service E-mail Address

The Claims Administrator has consolidated its customer service e-mails into a single, easy-to-read address: help@bcbsla.com. Plan Participants who need to contact the Claims Administrator may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit **www.bcbsla.com** and click on "Contact Us."

ARTICLE II. DEFINITIONS

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

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

Adverse Determination – Means denial or partial denial of a Benefit, in whole or in part, based on:

A. Medical Necessity, appropriateness, health care setting, level of care, effectiveness or treatment is determined to be experimental or Investigational;

B. the Plan Participant's eligibility to participate in the Benefit Plan;

C. any prospective or retrospective review determination; or

D. a Rescission of coverage.

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

Allied Health Professional - A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, and/or approved by Us to render Covered Services. For coverage purposes under this Plan, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified nurse practitioners, certified nurse midwives, optometrists, pharmacists, chiropractors, podiatrists, Physician assistant, registered nurse first assistant, advanced practice registered nurse, licensed professional counselors, certified registered nurse anesthetists, licensed clinical social workers, and any other health professional as mandated by state law for specified services, if approved by the Claims Administrator to render Covered Services.

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

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

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

Ambulance Service - Medically Necessary transportation by a specially designed emergency vehicle for transporting the sick and injured. The vehicle must be equipped as an emergency transport vehicle and staffed by trained ambulance personnel as required by appropriate State and local laws governing an emergency transportation vehicle.

Annual Enrollment – A period of time, designated by the Group, during which an Employee/Retiree may enroll for Benefits under this Benefit Plan.

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

Appeal - A request from a Plan Participant or authorized representative to change an Adverse Determination made by the Claims Administrator.

Applied Behavior Analysis (ABA) - The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Providers of ABA shall be certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board.

Authorization (Authorized) – A determination by Claims Administrator regarding an Admission, continued Hospital stay, or other health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the health care setting, or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Plan Participant's choice of Provider.

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

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

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

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

Benefit Plan - This Plan established by the Group to provide medical Benefits for eligible Plan Participants.

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

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

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

Child or Children – includes:

A. a Child of the Employee/Retiree;

B. a Child of the Employee/Retiree's Spouse;

C. a Child placed for adoption with the Employee/Retiree through an agency adoption;

D. a Child under the court-ordered legal guardianship or in the court-ordered custody of the Employee/Retiree;

E. a grandchild of the Employee/Retiree whose parent is covered under the Plan as a Dependent, or a child for whom the Employee/Retiree has current provisional custody, which grandchild/child has not been adopted by the Employee/Retiree and for whom the Employee/Retiree has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a "Child" as of December 31, 2015.

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

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

Claim Administrator - The entity with whom the Group (Plan Administrator/Sponsor) has contracted to handle the Claims payment functions of its Plan. For purposes of this Plan, the Claims Administrator is HMO Louisiana, Inc.

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

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and its regulations.

Code – The Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.

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

Company – HMO Louisiana, Inc.

Complaint - An oral expression of dissatisfaction with Us or with Provider services.

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

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

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

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

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

Copayment (Copay) - The specific dollar amount a Plan Participant must pay when specified Covered Services are rendered. Copayment amounts are listed in the Schedule of Benefits and may be collected directly from the Plan Participant by a Network Provider. The Plan Participant is responsible for paying the lesser of:

- The applicable Copayment, or
- The Allowable Charge.

In most cases, the Deductible and Coinsurance will be waived for Copayment services. See the Schedule of Benefits for additional information.

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

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

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

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

Date Acquired – The date a Dependent of a covered Employee/Retiree is acquired in the following instance and on the following dates only.

A. Spouse – the date of marriage

B. Child or Children:

   1. Natural Children – the date of birth;

   2. Children placed for adoption with the Employee/Retiree:

      Agency adoption – the date the adoption contract was executed between the Employee/Retiree and the adoption agency;

      Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee/Retiree. The Plan Administrator must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;

3. Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship – the date of the court order granting legal custody or guardianship, or of the notarized act granting provisional custody; and

4. Stepchild – the date of the marriage of the Employee/Retiree to his/her Spouse.

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

Deductible Amounts

A. Individual Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Plan Participant must pay within a Benefit Period before the Plan starts paying Benefits. Once the Family Deductible Amount is satisfied, this Plan starts paying Benefits for all Plan Participants of the family, regardless whether each has met his Individual Deductible Amount. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits.

   Network and Non-Network Benefit categories may each carry a separate Individual Deductible Amount as shown in the Schedule of Benefits.

B. Family Deductible Amount – For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Individual Deductible Amount. The Family Deductible Amount is met when the total dollar amount of charges for Covered Services, applied to satisfy Individual Deductibles, meets or exceeds the Family Deductible Amount shown in the Schedule of Benefits. This Plan will then start paying Benefits for all Plan Participants within the family, regardless of whether each Plan Participant has met his Individual Deductible. No Plan Participant may contribute more than his Individual Deductible Amount towards satisfying the Family Deductible Amount. Only Individual Deductible Amounts accrue to the Family Deductible Amount. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan.

   Network and Non-Network Benefit categories may each carry a separate Family Deductible Amount as shown in the Schedule of Benefits.

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

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

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

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

Dependent – Any of the following persons who are enrolled for coverage as Dependents by completing appropriate enrollment documents and whose relationship to the Employee/Retiree has been documented. Anyone covered as an Employee/Retiree may not also be covered as a Dependent.

A. the covered Employee's Spouse; and/or

B. A Child from Date Acquired until end of month of attainment of age twenty-six (26); except for the following:

1. A grandchild of the Employee/Retiree whose parent is covered under the Plan as a Dependent and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which grandchild was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until end of month the parent Dependent Child reaches the age of twenty six (26) or the grandchild no longer meets the eligibility requirements under this Plan, whichever is earlier;

2. A child for whom the Employee/Retiree has current provisional custody and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which child was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until the provisional custody term ends, the end of the month the child reaches the age of majority, or the child no longer meets the eligibility requirements under this Plan, whichever is earlier;

3. A Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship/tutorship but who has not been adopted by the Employee/Retiree, from Date Acquired until the custody/guardianship/tutorship order expires or the end of the month the Child reaches the age of majority, whichever is earlier.

C. A Child of any age who meets the criteria set forth in the Eligibility Article of this Benefit Plan.

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

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

Effective Date - The date when a Plan Participant's coverage begins under this Benefit Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 AM on this date.

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

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

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

Emergency - See "Emergency Medical Condition."

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

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

Emergency Medical Services – Any health care service provided to evaluate and/or treat an Emergency Medical Condition requiring immediate unscheduled medical care.

Employee - A full-time, active Employee or Full-Time Equivalent of the Employer. An Employee is considered to be full-time if he normally works at least thirty hours per week and is on the regular payroll of the Employer for that work.

Employer – East Baton Rouge Parish School System

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

Expedited Appeal - A request for immediate review of an Adverse Determination involving an Admission, availability of care, continued stay, or health care service for which a Plan Participant has received Emergency services, but has not been discharged from a facility.

Expedited External Appeal - A request for immediate review, by an Independent Review Organization (IRO), of an initial Adverse Determination, which involves any of the following:

A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function, or a decision not to Authorize continued services for Plan Participants currently in the Emergency room, under observation, or receiving Inpatient care.

B. A denial of coverage based on a determination the recommended or requested health care service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Plan Participant's health, including severe pain, potential loss of life, limb or major bodily function.

External Appeal – A request for review by an Independent Review Organization (IRO), to change a final Adverse Determination rendered on Appeal. External Appeal is available by request from the Plan Participant or his authorized representative for Adverse Determinations involving Medical Necessity, appropriateness of care, health care setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission.

Full-Time Equivalent (FTE) – A full-time equivalent Employee who is employed on average 30 or more hours per week, as defined under Code section 4980H and determined pursuant to the regulations issued thereunder.

Grievance - A written expression of dissatisfaction with Us or with Provider services.

Group - East Baton Rouge Parish School System (EBRPSS) who is the plan sponsor of this Benefit Plan and for whom HMO Louisiana, Inc. provides Claims administration services.

Habilitative Care – Health care services and devices that help a patient keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance Marketplace (Marketplace) – An organization operated by the federal government for the State of Louisiana, under Section 1311 of the Patient Protection and Affordable Care Act, to facilitate the purchase of health insurance.

High Tech Imaging – Imaging services which include, but are not limited to MRIs, MRAs, CT scans, PET scans and nuclear cardiology.

HIPAA – The Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and federal regulations promulgated pursuant thereto.

HIPAA Special Enrollment Event – An event as specified by federal law that entitles an Employee and the Employee's Dependents an opportunity to enroll in, and change, if desired, healthcare coverage offered by the Group outside of Annual Enrollment.

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

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

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

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

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

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

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

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

Inpatient Hospital Copayment Amount – The dollar amount, shown in the Schedule of Benefits, of charges for Covered Services rendered by a Hospital, which a Plan Participant must pay for each Admission. The Inpatient Hospital Copayment Amount does NOT accrue to the Individual Deductible Amount and must be paid in addition to the Individual Deductible Amount.

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

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

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

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

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

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

    3. reference to federal regulations.

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

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

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

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

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

Mental Disorder (Mental Health) - A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychoses, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by Louisiana state law at La. R.S. 22:1043 (formerly 22:669) (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under seventeen (17) years of age; Rett's Disorder; and Tourette's Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic Mental Disorders, to be determined by the Company. The definition of Mental Disorder shall be the basis for determining benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Network Benefits - Benefits for care received from a Network Provider, also referred to as In-Network Benefits.

Network Provider - A Provider that has signed an agreement with HMO Louisiana, Inc. to participate as a member of the HMO Network. This Provider may also be referred to as an HMOLA Provider or In-Network Provider.

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

Non-Network Benefits – Benefits for care received from Non-Network Providers, also referred to as Out-of-Network Benefits.

Non-Network Provider - A Provider who is not a member of the Claims Administrator's HMOLA Network. Participating Providers and Non-Participating Providers are Non-Network Providers as they are not contracted with HMO Louisiana, Inc.

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

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

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

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

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

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

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

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

Plan – East Baton Rouge Parish School System's medical Benefits plan for certain Employees of East Baton Rouge Parish School System and is described in this document.

Plan Administrator – The person or entity designated by the Plan Sponsor to administer this group Plan. If no one is designated, Plan Sponsor is Plan Administrator.

Plan Participant – An Employee, Retiree, Active Bus Driver, Cafeteria Worker or School Board Plan Participant who has satisfied the specifications of this Benefit Plan's Schedule of Eligibility and has enrolled for coverage.

Plan Sponsor – East Baton Rouge Parish School System**,** who provides these Benefits on behalf of its eligible Employees, Retirees and their eligible Dependents.

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

Pre-Existing Condition – A physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specific period of time prior to the Enrollment Date or the first day of coverage under another health plan.

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

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

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

Primary Care Physician (PCP) - A Physician who is a Family Practitioner, General Practitioner, Internist, or Pediatrician and who has entered into a contract with the Claims Administrator to participate in its HMOLA Network.

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

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

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

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

A. HMOLA Provider - A Provider that has a signed contract with the Claims Administrator to participate in the HMOLA Network. This Provider is also referred to as a Network Provider.

B. Participating Provider - A Provider that does not have a signed contract with the Claims Administrator, but has a signed contract with the Our parent company, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan to participate in its Provider networks.

C. Non-Participating Provider - A Provider that does not have a signed contract with the Claims Administrator, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.

Rehabilitative Care - Health care services and devices that help a person keep, resume or improve skills and functioning for daily living that have been lost or impaired because a patient was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Rescission – Cancellation or discontinuance of coverage that has retroactive effect. This includes a cancellation that treats a Plan Participant's coverage as void from the time of enrollment or a cancellation that voids Benefits paid up to one year before the cancellation.

Residential Treatment Centers – A twenty-four (24) hour, non-acute care treatment setting for the active treatment of specific impairments of mental health or substance abuse.

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

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

A. Immediately received a retirement plan distribution from an approved state or state governmental agency defined benefit plan;

B. Was not eligible for participation in such a plan or had legally opted not to participate in such a plan, and either:

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

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

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

    4. Maintained continuous coverage with the Plan as an eligible Dependent until he became eligible to receive a retirement benefit from an approved state governmental agency defined benefit plan as a former state employee.

C. Immediately received a retirement plan distribution from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan shall be responsible for certification of eligibility hereunder to the Plan Administrator.

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

Service Area - Those parishes in Louisiana shown in the HMO Louisiana, Inc. Provider Directory, which lists all HMO Louisiana, Inc. Network Physicians, Hospitals and Allied Providers in the Service Area.

Skilled Nursing Facility or Unit - A facility licensed by the state in which it operates and is other than a nursing home or a unit within a Hospital (unless skilled nursing in the nursing home or unit within a Hospital was specifically approved by Us), that provides:

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

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

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

D. Utilization review plans for all patients.

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

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

Specialist - A Physician who is not practicing in the capacity of a Primary Care Physician.

Specialty Drugs - Specialty Drugs are typically high in cost and have one or more of the following characteristics:

A. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.

B. Coordination of care is required prior to drug therapy initiation and/or during therapy.

C. Unique patient compliance and safety monitoring requirements.

D. Unique requirements for handling, shipping and storage.

E. Restricted access or limited distribution

Specialty drugs also include biosimilars. Biosimilars are drugs that are similar to currently marketed Brand Name drugs, but do not have the exact same active ingredient. Biosimilars are not considered Generic Drugs.

Speech/Language Pathology Therapy - The treatment used to manage speech/language, cognitive-communication and swallowing disorders. Goals are directed towards improving or restoring function

Spouse – The Employee's Spouse pursuant to a marriage recognized under state law where the marriage was entered.

Surgery -

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

B. The correction of fractures and dislocations.

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

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

E. Other procedures that We define and approve.

Telemedicine – Health care delivery, diagnosis, consultation, treatment and transfer of medical data by a Physician or Nurse Practitioner in the HMOLA Network using interactive telecommunication technology. The Network Physician or Nurse Practitioner at one location is able to interact with the Plan Participant at a separate location, via simultaneous two-way video and audio transmission. Telemedicine does not include telephone conversations or electronic mail messages between a Provider and a Plan Participant.

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

Temporary Employee – An Employee who is employed for 120 consecutive, calendar days or less.

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

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

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

Utilization Management - Evaluation of necessity, appropriateness and efficiency of the use of health care services, procedures and facilities.

Waiting Period - see "Eligibility Waiting Period."

Well Baby Care - Routine examinations of an infant under the age of twenty-four (24) months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the Routine Wellness Physical Exam Benefit.

ARTICLE III. SCHEDULE OF ELIGIBILITY

The Plan Administrator has full discretionary authority to determine eligibility for coverage / Benefits and to construe the terms of this Plan. A Temporary Employee does not meet the eligibility requirements under this Benefit Plan, unless such Employee is determined to be an FTE.

A. Persons to be Covered

1. Employees

   a. A full-time Employee as defined by the Employer and any FTE, both as determined in accordance with applicable state and federal law.

   b. Spouse

      If a covered Spouse is eligible for coverage as an Employee and chooses at a later date to be covered separately, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase Benefits.

   c. Re-enrollment; Previous Employment

      Full-time Employees returning to full time or part-time status with less than thirteen (13) weeks (less than 26 weeks for educational institutions) since separation or termination may resume coverage if application is made within thirty (30) days following return to work. Coverage will resume on the first of the month following return to work. If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within thirty (30) days of re-employment.

   d. Board Members

      Members of school boards, state boards, or commissions, defined by the Group as full-time Employees, are eligible to participate in this Benefit Plan.

2. Retirees

   A person meeting the definition of "Retiree" shall be eligible for coverage under this Benefit Plan. Retirees may not be covered as an Employee.

   Retired participants of the EBRPSS medical plans and their covered dependent spouses, who reach age sixty-five (65) on or after June 1, 2005, must enroll in Medicare Parts A and B in order for their claims to be paid under this Plan. If a retired participant or covered spouse are eligible for Medicare, but do not enroll for Parts A and B, the claims of the person eligible for Medicare will be denied.

   Medicare pays primary coverage for those retired participants and their covered dependent spouses who are enrolled in Parts A and B. The EBRPSS medical plan will pay secondary to Medicare for such persons. The retired participant’s claim cannot be processed until the EBRPSS medical plan claims administrator receives an explanation of benefits from Medicare indicating what Medicare paid as primary coverage.

   The above provisions do not apply to a covered dependent spouse under age sixty-five (65) or the dependent eligible retired participants who are under age sixty-five (65) and their covered dependents. Coverage for such persons will continue to be provided as primary under the EBRPSS medical plans.

   Retired participants not entitled to Medicare Parts A and B must supply EBRPSS the appropriate documentation from the Social Security Administration evidencing denial of entitlement. The EBRPSS medical plan in force will continue to provide primary coverage for retired participants who are not entitled to Medicare.

3. Documented Dependents

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

(1) The date the Employee or Retiree becomes eligible, or

(2) The Date Acquired for Employee's or Retiree's Dependents.

b. The following written proof of relationship to the Employee or Retiree must be presented to the Plan Administrator, or representative designated by the Plan Administrator, for inspection and copying.

(1) Spouses - A certified copy of the certificate of marriage, indicating date and place of marriage.

(2) Child or Children.

(a) Natural or legally adopted Child or Children of Employee/Retiree – Certified copy of birth certificate listing Employee/Retiree as parent or certified copy of legal acknowledgment of paternity signed by the Employee/Retiree or certified copy of adoption decree naming Employee/Retiree as adoptive parent.

(b) Stepchild – Certified copy of certificate of marriage to Spouse and birth certificate or adoption decree listing Spouse as natural or adoptive parent.

(c) Child placed with Your family for adoption by agency adoption or irrevocable act of voluntary surrender for private adoption – Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender.

(d) Child for whom You have been granted court-ordered legal guardianship or court-ordered custody – Certified copy of the signed court order granting legal guardianship or custody.

(e) Child age 26 or older who is incapable of self-sustaining employment and who was covered prior to and upon attainment of age 26 – Documentation as described in A.3.b.(2)(a-d) above, together with an application for continued coverage and supporting medical documentation which must be received by the Plan Administrator prior to the Child's attainment of age 26, as well as additional medical documentation of Child's continuing condition periodically upon request by the Plan Administrator.

(f) Medical Child Support Orders

A Dependent Child shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). An Employee who is not currently enrolled in the Plan may enroll to effect coverage for his Dependent(s) who are the subject of the QMCSO. A QMCSO is a state court order or judgment, including approval of a settlement agreement that:

(i) Provides for support of a covered Plan Participant's Dependent Child;

(ii) Provides for health care coverage for that Dependent Child;

(iii) Is made under state domestic relations law (including a community property law);

(iv) Relates to Benefits under the Plan; and

(v) Is "qualified" in that it meets the technical requirements of applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the Dependent Child of a non-custodial parent who is (or will become) a Plan Participant by a domestic relations order that provides for health care coverage.

(3) Such other written proof of relationship to the Employee/Retiree deemed sufficient by the Plan Administrator.

B. Enrollment for Coverage

An enrollment form must be completed within thirty (30) days of eligibility for coverage.

C. Available Classes of Coverage

1. Employee Only coverage means coverage for the Employee only.

2. Employee and Spouse coverage means coverage for the Employee and his/her spouse.

3. Employee and Child(ren) coverage means coverage for the Employee and one or more Dependents.

4. Family coverage means coverage for the Employee, his spouse, and one or more Dependents.

D. Change of Classification

1. Adding or Deleting Dependents

   When a Dependent is added to the Employee's/Retiree's coverage as a result of a HIPAA Special Enrollment Event or deleted from the Employee's/Retiree's coverage consistent with a change in the Dependent's status, application made by an active Employee or Retiree shall be provided to the Plan Administrator. Application is required to be made within thirty (30) days of the HIPAA Special Enrollment Event or change in status unless otherwise specified in this Plan document or unless a longer application period is required by federal or state law. When a Dependent is added to or deleted from coverage during a designated enrollment period, application is required to be made as directed by the Plan Administrator for the designated enrollment period.

2. Change in Coverage

   When the addition of a Dependent as a result of a HIPAA Special Enrollment Event results in a change in classification, the change in classification will be effective on the date of the HIPAA Special Enrollment Event.

3. Notification of Change

   It is the Employee's / Retiree's responsibility to make application for any change in classification of coverage.

E. Effective Date of Coverage

1. New Employee, Transferring Employee and FTE

   Coverage for an Employee who completes the applicable enrollment form and agrees to make the required Employee contribution is effective as follows:

a. For new full-time Employees, if employment begins on the first day of the month, coverage is effective the first day of the following month (for example, if hired on July 1st, coverage will begin on August 1st).

b. For new full-time Employees, if employment begins on or after the second day of the month, coverage is effective the first day of the second month following employment (for example, if hired on July 15th, coverage will begin on September 1st).

c. Employee coverage will not become effective unless the Employee completes enrollment form within thirty (30) days following the date of employment If completed after thirty (30) days following the date of employment, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

d. An Employee who transfers employment to this Employer from another Participant Employer must complete a transfer form within thirty (30) days following the date of transfer in order to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

e. An Employee who is determined to be an FTE will be allowed to enroll in this Benefit Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth month of employment for those Employees determined to be FTEs during their initial measurement period.

2. Retiree

Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree agrees to make and is making the required contributions. For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. For example, if date of retirement is July 15, Retiree coverage will begin August 1; if date of retirement is August 1, Retiree coverage will begin September 1.

3. Documented Dependents of Employees

Coverage will be effective on the Date Acquired.

4. Documented Dependents of Retirees

Coverage will be effective on the first day of the month following the date of retirement if the Retiree and his Dependents were covered immediately prior to retirement Coverage for Dependents of Retirees first becoming eligible for Dependent Coverage following the date of retirement will be effective on the Date Acquired.

F. HIPAA Special Enrollment Events

Certain eligible persons may enroll by written application as provided by HIPAA under the following circumstances, terms, and conditions for special enrollments.

1. Loss of Other Coverage

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

(1) Loss of eligibility through legal separation, divorce, annulment, termination of employment, reduction in hours, or death of the Spouse; or

(2) Cessation of Employer contributions for the other coverage, unless the Employer's contributions were ceased for cause or for failure of the Employee or Dependent (as applicable) to make contributions; or

(3) The Employee or Dependent having had COBRA continuation of coverage under a group health plan and the COBRA continuation coverage has been exhausted, as provided in HIPAA; or

(4) Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or

b. Eligibility for premium assistance subsidy under Medicaid or SCHIP.

c. A special enrollment application must be made within thirty (30) days of either the termination date of the prior coverage or the Date Acquired for new Dependents, or within sixty (60) days as identified in 1.a.(4) and 1.b. above.

2. Retirees Special Enrollment

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

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

b. The Retiree can document that Creditable Coverage was in force at the time of the election not to participate or continue participation in this Benefit Plan;

c. The Retiree can demonstrate that Creditable Coverage was maintained continuously from the time of the election until the time of requesting special enrollment;

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

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

3. Effective Date of Coverage for Special Enrollees

The Effective Date of Coverage for Special Enrollees who timely enroll shall be:

a. For loss of other coverage or marriage, the first of the month following the date of the Plan Administrator receives all required forms for enrollment;

b. For birth of a Dependent, the date of birth;

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

d. Medicare Advantage Option for Retirees

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

(1) during the month of November, for coverage effective January 1; or

(2) during the next Annual Enrollment, for coverage effective at the beginning of the next Plan Year.

Retirees who elect to participate in a Medicare Advantage Plan not sponsored by the Group will not be allowed to reenroll in this Plan upon withdrawal from or termination of coverage in the Medicare Advantage Plan. If the Group does not sponsor a Medicare Advantage Plan when the eligible Retiree elects to participate in a Medicare Advantage Plan, this restriction will not apply should the Retiree later wish to reenroll in this Plan.

e. TRICARE for Life Option for Military Retirees

Retirees eligible to participate in the TRICARE for Life (TFL) option on and after October 1, 2001, who cancel coverage with the Benefit Plan upon enrollment in TFL may re-enroll in the Benefit Plan in the event that the TFL option is discontinued or its benefits significantly reduced.

ARTICLE IV. BENEFITS

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

A. Benefit Categories

The Point of Service Benefit Plan includes the following categories of Benefits:

1. Network Benefits – Benefits for Covered Services received from an HMOLA Provider. When a Plan Participant receives care from a Network Provider, he will receive the highest level of Benefits on this Plan.

   The Plan Participant must pay all Copayments, Deductible Amounts, and applicable Coinsurance percentages shown in the Schedule of Benefits for a specified Covered Service each time the Covered Service is rendered by a Network Provider, subject to any limitations or maximum Benefits shown. These amounts are subject to change from time to time.

2. Non-Network Benefits – Benefits for Covered Services received from a Provider who is not contracted with the Claims Administrator as a HMOLA Provider. Participating Providers and Non-Participating Providers are not contracted with HMO Louisiana, Inc. When a Plan Participant receives care from a Non-Network Provider, he will receive a lower level of Benefits on this Plan.

   After any Deductible Amounts shown in the Schedule of Benefits have been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, We will provide Benefits in the Coinsurance percentages shown in the Schedule of Benefits toward Allowable Charges for Covered Services rendered to a Plan Participant by Non-Network Providers during a Benefit Period. The Claims Administrator's actual payment to a Provider or payment to the Plan Participant satisfies the Plan's obligation to provide Benefits under this Benefit Plan. Deductible Amounts, Copayments and Coinsurance percentages are subject to change from time to time.

   NOTE: No Benefits are available for Organ, Tissue and Bone Marrow Transplants or evaluations if Authorization is not received prior to services being rendered. Additionally, Network Benefits paid by the Claims Administrator to an HMO Network Provider may be reduced for the Provider's failure to obtain prior Authorization from Us when required to do so. Refer to the Care Management Article of this Benefit Plan and the Schedule of Benefits for additional information.

B. Deductible and Coinsurance

1. We will apply the Plan Participant's Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by the Claims Administrator. Our system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the

Plan Participant may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met.

The following Deductibles may apply to Benefits provided by this Plan:

a. Individual Deductible Amount: The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that the Plan Participant must pay within a Benefit Period before the Plan starts paying Benefits. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits.

b. Family Deductible Amount: For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Individual Deductible Amount. Once the family has met its Family Deductible Amount, this Benefit Plan starts paying Benefits for all covered members of the family, even if each covered family member has not met his Individual Deductible. No Plan Participant may contribute more than his Individual Deductible Amount to satisfy the maximum amount required of a family. Only Individual Deductible Amounts accrue to the Family Deductible Amount.

2. The Coinsurance percentage is shown on the Schedule of Benefits for a Covered Service. The Plan Participant must first pay any applicable Deductible Amount before the Coinsurance percentage. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in the Coinsurance percentages shown in the Schedule of Benefits toward Allowable Charges for Covered Services. The actual payment to a Provider or payment to the Plan Participant satisfies the Plan Sponsor's obligation to provide Benefits under this Benefit Plan.

3. This Benefit Plan does not provide a fourth-quarter Deductible carryover for charges incurred for Covered Services incurred during the months of October, November and December.

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

5. Under certain circumstances, if the Plan pays a healthcare Provider amounts that are the Plan Participant's responsibility, such as Deductibles, Copayments or Coinsurance, the Plan may collect such amounts directly from You.

C. Copayment Services

The Plan Participant must pay a Copayment each time applicable Covered Services are rendered, until the Plan Participant meets his Out-of-Pocket Amount. The amount of the Copayment depends upon the type of Network Provider rendering the service. Office visit Copayments will be at the Primary Care Physician (PCP) or Specialist amount shown on the Schedule of Benefits.

Plan Participants pay the lowest office visit Copayment when obtaining care from a PCP. PCPs are family practitioners, general practitioners, internists and pediatricians. Each member of the family may use a different PCP. PCPs will coordinate health care needs from consultation to hospitalization, will direct a Plan Participant to an appropriate Provider when necessary, and will assist in obtaining any required Authorizations.

If one Provider directs a Plan Participant to another Provider, the Plan Participant must make sure that the new Provider is in the HMOLA Network before receiving care. If the new Provider is not in the HMOLA Network, Benefits will be processed at the Non-Network Benefit level and the Allowable Charge applicable to that Provider.

1. The office visit Copayment means Outpatient services when rendered in the office or clinic of an HMOLA Provider who is a Physician, Osteopath or other Network Provider shown in the Schedule of Benefits.

   Examples of Covered Services subject to Copayments:

   a. Office visit charges and Consultation;

   b. X-rays;

   c. Laboratory tests. Laboratory tests that are processed and completed within the Physician's office or clinic will be subject to the Physician office visit Copayment. Laboratory tests that are sent out of the Physician's office or clinic for processing may be subject to the Deductible Amount and Coinsurance;

   d. Machine tests (except for MRI);

   e. Injections,

   f. Surgical procedures; and/or

2. Copayment services do not apply to every service and/or supply rendered in an office setting. Examples of services and/or supplies that are subject to the Individual Deductible Amount and applicable Coinsurance percentage are listed below:

   a. Allergy testing, allergy serums, and vials of allergy medications;

   b. Physical Therapy, Occupational Therapy, and Speech Therapy;

   c. High Tech Imaging, including but not limited to MRI, MRA, CT scans, PET scans and nuclear cardiology;

   d. Medical and surgical supplies; and/or

   e. Durable Medical Equipment.

D. Out-of-Pocket Amount

1. After the Plan Participant has met the applicable Out-of- Pocket Amount, as shown in the Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Allowable Charges for Covered Services for all covered family members for the remainder of the Benefit Period.

2. The following accrue to the Out-of-Pocket Amount of this Benefit Plan:

   a. Deductible Amounts

   b. Coinsurance

   c. Copayment Amounts

   d. Inpatient and Outpatient facility Copayment Amounts

3. The following do not accrue to the Out-of-Pocket Amount of this Benefit Plan:

    a. any charges in excess of the Allowable Charge;

    b. any penalties the Plan Participant or Provider must pay;

    c. charges for non-covered services; and

    d. any other amounts paid by the Plan Participant other than Deductibles, Coinsurance and Copayments.

ARTICLE V. HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-Emergency, Emergency, Pregnancy Care, Mental Health and substance abuse Admissions) must be Authorized as outlined in Care Management Article of this Benefit Plan. In addition, at regular intervals during the Inpatient stay, the Claims Administrator will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care. The Plan Participant must pay any Copayment, Deductible Amount and any Coinsurance percentages shown in the Schedule of Benefits. The following services furnished to a Plan Participant by a Hospital are covered.

If a Plan Participant receives services from a Physician in a hospital-based clinic, the Plan Participant may be subject to charges from the Physician and/or clinic as well as the facility.

A. Inpatient Bed, Board and General Nursing Service

1. In a semi-private room, where the Hospital provides semi-private rooms. The average semi-private room rate will be allowed toward a private room accommodation. If the facility does not offer semi-private rooms, the lowest private room rate will be allowed toward a private room accommodation.

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

3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us. Coverage limitations are shown in the Schedule of Benefits.

4. In a Residential Treatment Center for Plan Participants with Mental Health and substance abuse impairment.

B. Other Hospital Services (Inpatient and Outpatient)

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

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

3. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital employee.

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

5. Diagnostic Services rendered by a Hospital employee.

6. Physical Therapy provided by a Hospital employee.

7. Psychological testing when ordered by the attending Physician and performed by an employee of the Hospital.

C. Pre-Admission Testing Benefits

Pre-Admission Diagnostic Services in the Outpatient department of a Hospital within seven (7) days of a scheduled Admission to that Hospital.

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

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

A. Surgical Services

1. Surgery

   a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by the Plan and is that period of time which is appropriate as routine care for the particular surgical procedure.

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

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

   a. Primary Procedure

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

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

   b. Secondary Procedure(s)

      The secondary procedure(s) is a procedure(s) performed in addition to the primary procedure which adds significant time, risk, or complexity to the Surgery. The Allowable Charge for the secondary procedure will be based on a percentage of the Allowable Charge that would be applied had the secondary procedure been the primary procedure. Benefits will not exceed fifty percent (50%) of the Allowable Charge for each procedure.

   c. Incidental Procedure

      No Benefits are allowed for an incidental procedure.

   d. Unbundled Procedure(s)

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

e. Mutually Exclusive Procedure(s)

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

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

3. Assistant Surgeon

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

4. Anesthesia

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

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

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

5. Second Surgical Opinion

Benefits will be provided for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. Second surgical opinions are covered, subject to any applicable Copayments, Coinsurance and Deductible Amounts, but are not mandatory in order to receive Benefits.

B. Inpatient Medical Services

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

1. Inpatient medical care visits;

2. Concurrent Care; and

3. Consultation (as defined in this Benefit Plan)

C. Outpatient Medical and Surgical Services

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

2. Consultation (as defined in this Benefit Plan);

3. Diagnostic Services;

4. services of an Ambulatory Surgical Center; and

5. services of an Urgent Care Center.

D. Expanded Medical and Surgical Benefits

The Plan may provide coverage to Plan Participants above and beyond the Benefits stated in this Benefit Plan when, in Plan Sponsor's discretion, it determines that a disaster, state of emergency or other event may disrupt or seriously threaten to disrupt health care or other services provided for under this Benefit Plan.

ARTICLE VII. PREVENTIVE OR WELLNESS CARE

Preventive and Wellness Care services are covered unless otherwise noted in the service description. New services are also covered when required by law.

This Benefit Plan covers services recommended by the U.S. Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. The list of covered services changes from time to time. New Preventive or Wellness Care services usually become covered within one year from the date recommended. To check the current list of recommended services, visit the U.S. Department of Health and Human Services' website at: **https://www.healthcare.gov/preventive-care-benefits/** or contact Our customer service department at the telephone number on Your ID card.

A. Preventive or Wellness Care Benefits

The Deductible Amount does not apply to covered Preventive or Wellness Care. Benefits will be paid at one hundred percent (100%) of the Allowable Charge.

B. The following Preventive or Wellness Care services are available to a Plan Participant.

PREVENTIVE or WELLNESS CARE SERVICES	AGE / CRITERIA
EXAMINATIONS AND TESTING – ALL ADULTS	
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels). Higher tech services such as an MRI, MRA, CT scan, PET scan, nuclear cardiology, and endoscopy are not covered under this Preventive or Wellness Benefit but may be covered under standard Benefits.	All Ages
Colorectal Cancer Screening –	
• Fecal immunochemical test for blood (FIT): One (1) per Benefit Period.	Ages 50 – 75
• Flexible sigmoidoscopy: One (1) every five (5) years.	Ages 50 – 75
• Colonoscopy: One (1) every ten (10) years.	Ages 50 – 75
• Physician prescribed colonoscopy preparation medications: Limit of two (2) prescriptions for selected generic drugs.	Ages 50 – 75
Any additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Services deemed Investigational are not covered.	
• Other Grade A and B screening procedures as most recently recommended by the United States Preventive Services Task Force (USPSTF) and the American College of Gastroenterology, in consultation with the American Cancer Society.	Ages 50 – 75
IMMUNIZATIONS – ALL ADULTS	
Immunizations recommended by Physician	All Ages
Seasonal Flu and H1N1 Immunizations	All Ages
SCREENINGS, COUNSELING AND SUPPLEMENTS – ALL ADULTS	
Alcohol Misuse Screening and Counseling	Adults: Ages 18 and older
Aspirin Counseling for Prevention of Cardiovascular Disease	Men: Ages 45 – 79 Women: Ages 55 – 79
Blood Pressure Screening	Ages 18 and older
Cardiovascular Disease Counseling	Adults who are overweight or obese and have additional risk factors
Cholesterol Screening	Men: Ages 20 – 35 if at risk; or 35 and older Women: Ages 20 – 45 if at risk; or 45 and older

Depression Screening	All Ages
Diet Counseling	Adults with hyperlipidemia and other risk factors
Fall Prevention Intervention	Ages 65 and older
Generic/Single Source Brand Prescription and Over-the-Counter Smoking Cessation Products: Limit 180 days per calendar year	Ages 18 and older
Generic Vitamin D (up to 800 IU)	Ages 65 and older
Hepatitis B Screening	High risk adults
Hepatitis C Screening	High risk adults and **adults born between 1945 and 1965**
HIV Screening and Counseling	Ages 15 – 65; younger or older if at increased risk
Lung Cancer Screening	Ages 55 – 80 (per guidelines for smoking history)
Obesity Screening and Counseling	Adults with a body mass index higher than 30 kg/m^2
Sexually Transmitted Infection Counseling	Sexually active adults at increased risk
Skin Cancer Screening	Ages 10 – 24
Syphilis Screening	Adults at increased risk
Tobacco Use Screening and Counseling	All ages
Type 2 Diabetes Screening	Asymptomatic adults with blood pressure higher than 135/80 mmHg
COVERED SERVICES FOR FEMALES	
Contraceptives – All Food and Drug Administration approved methods, as prescribed by a Physician	Women with reproductive capacity
BRCA Genetic Testing – Screening and Counseling	Women with family history of risk (per guidelines)
Breast Cancer Chemoprevention Counseling	Women at risk for breast cancer
Chlamydia Infection Screening	Women ages 24 and younger who are sexually active; older if at increased risk

Generic Folic Acid Supplements (Prescription Drug Benefit) – 0.4mg to 0.8mg/day	Women who are planning or capable of pregnancy: Ages 15 – 44
Gonorrhea Screening	Women ages 24 and younger who are sexually active; older if at increased risk
Human Papillomavirus (HPV) DNA testing – Limit of one (1) every three (3) years, with all other testing processing according to standard Benefits	Ages 30 and older
Intimate Partner Violence Screening	Ages 14 – 46
Mammography Examination	Ages 35 – 39: Baseline Ages 40 – 49: 1 every 24 months or as doctor prescribes Ages 50 and older: 1 every 12 months
Medications for Risk Reduction of Primary Breast Cancer	Asymptomatic Women: Ages 35 years or older without a prior diagnosis of breast cancer and who are at increased risk for breast cancer
Osteoporosis Screening: One (1) per Benefit Period	Ages 65 or older; younger women at risk (per guidelines)
Permanent Sterilization Method	Women with reproductive capacity
Routine Gynecologist or Obstetrician Visits	As age and developmentally appropriate
Routine Pap Smear – One (1) per Benefit Period	Ages 21 – 65
Sexually Transmitted Infection Counseling	Sexually active women
Violence and Domestic Abuse Counseling – Annually	Women and adolescent females
COVERED SERVICES FOR PREGNANT FEMALES	
Aspirin – 81mg for prevention of preeclampsia, generic over-the-counter, (Prescription Drug Benefit)	Ages 54 or younger after 12 weeks of gestation
Anemia Screening	During pregnancy

Bacteriuria Screening	During 12 – 16 weeks of gestation or at first prenatal visit
Breast Feeding Intervention	During pregnancy and after birth
Gestational Diabetes Testing and Screening	Asymptomatic pregnant women after 24 weeks of gestation
Hepatitis B Screening	During first prenatal visit
Lactation Counseling	During pregnancy and after each birth
Lactation Supplies for Machine Use Only	During the postpartum period
Manual Breast Pump	During the postpartum period
Rh Incompatibility Screening	Pregnant women during 24 – 28 weeks of gestation if at risk or at first prenatal visit
Syphilis Screening	During pregnancy
Tobacco Use Screening and Interventions, with Expanded Counseling	During pregnancy
COVERED SERVICES FOR MALES	
Abdominal Aortic Aneurysm Screening: One (1) per Benefit Period	Men who have smoked: Ages 65 – 75
Prostate Cancer Screening – • Routine digital rectal exam: One (1) per Benefit Period • Second visit: For follow-up treatment within 60 days after the visit if it is related to a condition that is diagnosed or treated during the visit and recommended by a doctor.	Ages 50 and older or as recommended by doctor for ages 40 – 49 Older than 40 years
COVERED SERVICES FOR CHILDREN & ADOLESCENTS	
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels). Higher tech services such as an MRI, MRA, CT scan, PET scan, nuclear cardiology, and endoscopy are not covered under this Preventive or Wellness Benefit but may be covered under standard Benefits.	All ages

Well baby care	As recommended by physician for developmental milestones
Immunizations recommended by Physician	All Ages
Seasonal Flu and H1N1 Immunizations	All Ages
Alcohol and Drug Use Assessments	Ages 11 – 21
Autism Screening	Ages 1 – 2
Behavioral Assessments	Ages 0 – 21
Blood Pressure Screening	Ages 0 - 17
Cervical Dysplasia Screening	Adolescent Girls: Ages 11 - 21
Chlamydia Infection Screening	Ages 24 and younger who are sexually active
Congenital Hypothyroidism Screening	Newborns
Depression Screening	Ages 12 – 18
Developmental Screening	Varied Intervals: Ages 0 – 3
Dyslipidemia Screening	Varied intervals beginning at 24 months
Fluoride Chemoprevention Supplements	Ages 6 months – 5 years
Gonorrhea Prophylactic Ocular Medication	Newborns
Gonorrhea Screening	Ages 24 and younger who are sexually active
Hearing Screening: One (1) per Benefit Period.	Ages 0 – 21
Height, Weight and Body Mass Index Measurements	Ages 2 – 21
Hematocrit or Hemoglobin Screening	Varied intervals: Ages 4 months – 21 years
Hepatitis B Screening	High risk adolescents
HIV Screening and Counseling	Adolescents
Iron Supplement	Asymptomatic 6 – 12 months old if at risk
Intimate Partner Violence Screening	Ages 14 - 46
Lead Screening: One (1) per Benefit Period	Ages 0 – 6

Obesity Screening and Counseling	Ages 6 and older
Oral Health Assessment	Varied intervals between 6 months – 6 years
Phenylketonuria (PKU)	Newborns
Sexually Transmitted Infection Counseling	Sexually active adolescents
Sickle Cell Screening	Newborns
Skin Cancer Counseling	Ages 10 – 24
Tobacco Use Screening and Counseling	School-aged children and adolescents
Tuberculosis Screening: One (1) per Benefit Period	Ages 0 – 21
Violence and domestic abuse counseling	As needed
Vision Screening: One (1) per Benefit Period	Ages 0 – 21

ARTICLE VIII. MENTAL HEALTH BENEFITS

A. Treatment of Mental Disorders is covered. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treatment of Mental Disorders do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.

B. Inpatient treatment for Mental Disorders must be Authorized as provided in the Care Management Article of this Benefit Plan.

C. Plan Participants who have not yet reached their seventeenth (17th) birthday are eligible for Applied Behavior Analysis when the Claims Administrator Authorizes it for treatment of Autism Spectrum Disorders. Applied Behavior Analysis must be rendered by an appropriately licensed behavior analyst or certified assistant behavior analyst.

ARTICLE IX. SUBSTANCE ABUSE BENEFITS

A. Benefits for treatment of substance abuse are available. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.

B. Inpatient treatment for substance abuse must be Authorized as provided in the Care Management Article of this Benefit Plan, when coverage for substance abuse is provided.

ARTICLE X. ORAL SURGERY BENEFITS

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

A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.

B. Extraction of impacted teeth.

C. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.)

D. Excision of exostoses or tori of the jaws and hard palate.

E. Incision and drainage of abscess and treatment of cellulitis.

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

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

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

I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Plan Participant's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia Benefits are not available for treatment rendered for temporomandibular joint disorders.

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

ARTICLE XI. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

(Network Categories Only)

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

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

A. Acquisition Expenses

If a solid organ, tissue or bone marrow is obtained from a living donor for a covered transplant, the donor's medical expenses are covered as acquisition costs for the recipient under this Benefit Plan.

If any organ, tissue or bone marrow is sold rather than donated to a Plan Participant, the purchase price of such organ, tissue or bone marrow is not covered.

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) or by an HMOLA Network facility, unless otherwise approved by the Claims Administrator in writing. To locate an approved facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their ID card.

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

3. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedures.

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

C. Solid Human Organ Transplants

1. Liver;

2. Heart;

3. Lung;

4. Kidney;

5. Pancreas;

6. Small bowel; and

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

D. Tissue Transplant Procedures (Autologous and Allogeneic)

Tissue transplants (other than bone marrow) are covered under regular Benefits and do not require prior Authorization. However, if an Inpatient Admission is required, it is subject to the article on Care Management.

The following tissue transplants are covered:

1. Blood transfusions;

2. Autologous parathyroid transplants;

3. Corneal transplants;

4. Bone and cartilage grafting;

5. Skin grafting;

6. Autologous islet cell transplants; and

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

E. Bone Marrow Transplants

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

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

ARTICLE XII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

The Claims Administrator has several maternity programs available to help pregnant Plan Participants deliver healthy babies. Please call Our Customer Service Department at the number on the back of Your ID card when You learn You are having a baby. We will advise about the programs available to You.

Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a patient covered as an Employee or Dependent wife of an Employee whose coverage is in effect at the time such services are furnished in connection with her pregnancy.

An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a newborn's stay exceeds that of the mother. An Authorization is also required for a newborn that is admitted separately because of neonatal complications.

A. Pregnancy Care

1. Medical and Surgical Services

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

   b. Diagnostic Services.

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

   d. Medically Necessary abortion required in order to save the life of the mother.

2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above are covered. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care.

3. Elective deliveries prior to the thirty-ninth (39th) week of gestation are not covered unless shown to be Medically Necessary. Facility and other charges associated with an elective early delivery that is not Medically Necessary are also considered to be non-covered.

4. Network Benefits (as shown in the Schedule of Benefits)

    a. A Pregnancy Care Copayment applies to each pregnancy for Covered Services rendered by Network Providers.

    b. The Plan Participant must pay an Inpatient Hospital Admission Copayment for any hospitalization related to the pregnancy.

5. Non-Network Benefits (as shown in the Schedule of Benefits)

    The Plan Participant must pay the Pregnancy Care Coinsurance and Inpatient Hospital Admission Coinsurance, in addition to the applicable Deductible Amount.

B. Care for Newborn when Covered at birth as a Dependent

The Plan Participant must pay all applicable Copayments, Deductible and Coinsurance as shown in the Schedule of Benefits for Covered Services.

1. Medical and surgical services rendered by a Physician, for treatment of illness, pre-maturity, post-maturity, or congenital condition of a newborn and circumcision. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered under the Network Benefit category only.

2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, pre-maturity, post-maturity, or congenital condition of a newborn. Charges for a well newborn which are billed separately from the mother's Hospital bill are not covered. The Hospital (nursery) charge for a well newborn is included in the mother's Hospital bill for the covered portion of her Admission for Pregnancy Care.

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or Newborn earlier.

Also, under federal law, plans and issuers may not set the level of Benefits or Out-of-Pocket costs so that any later portion of the forty-eight (48) hours or ninety-six (96) hours stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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

ARTICLE XIII. REHABILITATIVE / HABILITATIVE CARE BENEFITS

TO RECEIVE BENEFITS, THE PLAN PARTICIPANT MUST OBTAIN AUTHORIZATION FOR CERTAIN SERVICES AS SHOWN IN THE SCHEDULE OF BENEFITS AND THE CARE MANAGEMENT ARTICLE.

Rehabilitative and Habilitative Care Benefits will be available for the following services and devices provided on an Inpatient or Outpatient basis:

- Physical Therapy
- Occupational Therapy

- Speech/Language Pathology Therapy

- Chiropractic Services

Benefits are available when services are rendered by a Provider licensed and practicing within the scope of his license. In order for care to be considered at an Inpatient rehabilitation facility, the Plan Participant must be able to tolerate a minimum of three (3) hours of active therapy per day.

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

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

Benefits under this Article are in addition to, but not a duplication of, the Benefits provided under any other provision of this Benefit Plan. Any Benefits provided under any other provision of this Benefit Plan will not be eligible Benefits under this Article.

A. Occupational Therapy

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

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

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

3. Prevention, wellness and education related services for Occupational Therapy shall not require a referral.

B. Physical Therapy

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

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

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

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

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

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

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

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

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

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered when performed by a Provider licensed to practice in the state in which the services are rendered and practicing within the scope of his license, including but not limited to a speech pathologist or by an audiologist, licensed to practice in the state in which services are rendered.

2. The therapy must be used to improve or restore speech language deficits or swallowing function.

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

D. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license. Chiropractic Services are not covered when maintenance level of therapy is attained.

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

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

ARTICLE XIV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

To receive Benefits, the Plan Participant must obtain Authorization for certain services as shown in the Schedule of Benefits and the Care Management Article. The Plan Participant must pay all Copayments, applicable Deductible Amounts and Coinsurance percentages. The following services, supplies or equipment are available to Plan Participants and may be subject to other limitations shown in the Schedule of Benefits.

A. Ambulance Service Benefits

1. Ground Ambulance Transport Services

a. Emergency Transport

Benefits are available for Ambulance Services for local transportation for Emergency Medical Conditions or Medically Necessary Inpatient Hospital services only as follows:

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

(2) for the Newly Born Infant, to the nearest Hospital or neonatal Special Care Unit for treatment of illnesses, injuries, congenital birth defects and complications of premature birth which require that level of care;

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

b. Non-Emergency Transport

Benefits will be available for Ambulance Services for local transportation of Plan Participants for non-emergency conditions to obtain medically necessary diagnostic or therapeutic Outpatient services (e.g., MRI, CT scan, dialysis, wound care, etc.), when the Plan Participant is bed-confined or his condition is such that the use of any other method of transportation is contraindicated.

The Plan Participant must meet all of the following criteria for bed-confinement:

(1) unable to get up from bed without assistance;

(2) unable to ambulate; and

(3) unable to sit in a chair or wheelchair.

c. Transport by wheelchair van is not a covered Ambulance Service.

2. Air Ambulance Transport Services

a. Emergency Transport

Benefits for air Ambulance Services are available for Emergency Medical Conditions or when the Plan Participant is in a location that cannot be reached by ground ambulance. For Emergency Medical Conditions, the air Ambulance Service must be specifically requested by police or medical authorities present at the site with the Plan Participant in order for air Ambulance Services to be covered.

b. Non-Emergency Transport

Air Ambulance Service situations require prior Authorization from the Company. If Authorization is not obtained prior to services being rendered, the services will not be covered.

For Air Ambulance Services, it is recommended that the Plan Participant verify the network participation status of the Air Ambulance Provider in the state or area the point of pick up occurs, based on zip code. To locate a Participating Network Provider in the state or area where You will be receiving services, please call 1-800-810-2583 or go to the Blue National Doctor & Hospital Finder at **http://provider.bcbs.com**. Search for an Air Ambulance Provider by using the point of pick up zip code in the search criteria.

3. Ambulance Service Benefits will be provided as follows:

a. If a Plan Participant pays a periodic fee to an ambulance membership organization with which the Company does not have a Provider agreement, Benefits for expenses incurred by the Plan Participant for its Ambulance Services will be based on any obligation the Plan Participant must pay that is not covered by the fee. If there is in effect a Provider agreement between the Company and the ambulance organization, Benefits will be based on the Allowable Charge.

b. The medical transport services must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits.

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

B. Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder is covered when rendered or prescribed by a Physician or Allied Health Professional.

C. Bone Mass Measurement

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

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

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

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

Deductible, Coinsurance, and /or copayment amounts are applicable. One (1) osteoporosis screening per Benefit Period is available to women age 65 and older, under the “Preventive or Wellness Care” Article of this Benefit Plan, at no cost to Members receiving care from a Network Provider.

D. Breast Reconstructive Surgical Services

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

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

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

   c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.

2. These Covered Services shall be delivered in a manner determined in Consultation with the Plan Participant and the Plan Participant’s attending Physician, if applicable, and will be subject to any Deductible Amounts, Copayments and Coinsurance

E. Cardiac Rehabilitation

Benefits will be provided for Covered Services rendered to a Plan Participant for cardiac rehabilitation. Covered Services must be:

1. Performed under the supervision of a Physician; and

2. In connection with a myocardial infraction, angioplasty (with or without stenting), or cardiac bypass Surgery; and

3. Initiated within twelve (12) weeks after other treatment for the medical condition ends.

F. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other life-threatening disease or condition. Coverage will be subject to any applicable terms, conditions and limitations that apply under this Benefit Plan, including Copayment, Deductible, or Coinsurance amounts shown in the Schedule of Benefits.

2. A “Qualified Individual” under this section means a Plan Participant that:

    a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition;

    b. And either,

        (1) The referring health care professional is a Participating Provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the requirements in paragraph a, above; or

        (2) The Plan Participant provides medical and scientific information establishing that the Plan Participant’s participation in such trial would be appropriate based upon the Plan Participant meeting the conditions described in paragraph a, above.

3. An “Approved Clinical Trial” for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that:

    a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

        (1) The National Institutes of Health.

        (2) The Centers for Disease Control and Prevention.

        (3) The Agency for Health Care Research and Quality.

        (4) The Centers for Medicare & Medicaid Services.

        (5) Cooperative group or center of any of the entities described in paragraphs (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

        (6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

    b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

    c. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

    d. The study or investigation is conducted by any of the below Departments, which study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

        (1) The Department of Veterans Affairs.

        (2) The Department of Defense.

        (3) The Department of Energy.

4. The following services are not covered:

    a. Non-health care services provided as part of the clinical trial;

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

c. The investigational drugs, devices, items or services themselves; and/or

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

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

a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other life-threatening disease or for the prevention or early detention of such diseases.

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

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

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

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

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

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

G. Diabetes Education and Training for Self-Management

1. Plan Participants that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by the Plan Participant's Physician.

2. Evaluation and training programs for diabetes self-management is covered, subject to the following:

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

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

H. Dietitian Visits

Benefits are available for visits to registered dietitians.

Dietitian visits for diabetics are available under a separate Benefit for diabetes self-management training and education.

I. Disposable Medical Equipment and Supplies

Disposable medical equipment or supplies which have a primary medical purpose are covered and are subject to reasonable quantity limits as determined by Us. The equipment and supplies are subject to the Plan Participant's medical Deductible and Coinsurance.

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

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

1. Durable Medical Equipment

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

      (1) It must withstand repeated use,

      (2) It must be primarily and customarily used to serve a medical purpose,

      (3) It must be generally not useful to a person in the absence of illness or injury, and

      (4) It must be appropriate for use in the patient's home.

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

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

      (2) At Our option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.

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

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

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

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

   c. Limitations in connection with Durable Medical Equipment.

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

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

      (3) There is no coverage for the repair or replacement of equipment lost or damaged due to neglect or misuse.

(4) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by Us.

2. Orthotic Devices

Benefits as specified in this section will be available for the purchase of Orthotic Devices and will be subject to the following:

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

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

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

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

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

3. Prosthetic Appliances and Devices (Non-Limb)

Benefits will be available for the purchase of Prosthetic Appliances and Devices (other than limb prosthetics and services) that We Authorize and are covered subject to the following:

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

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

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

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

4. Prosthetic Appliances and Devices and Prosthetic Services of the Limbs

Benefits will be available for the purchase of Prosthetic Appliances and Devices and Prosthetic Services of the limbs that We Authorize, and are covered subject to the following:

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

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

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

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

K. Home Health Care Benefits

Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered.

Coverage for Home Health Care services is subject to limitations as shown in the Schedule of Benefits.

L. Hospice Benefits

Hospice Care is covered

Coverage for Hospice Care is subject to limitations as shown in the Schedule of Benefits.

M. Permanent Sterilization Procedures

Benefits are available for surgical procedures that result in permanent sterilization, including vasectomy.

Tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes are covered under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Network Provider.

N. Private Duty Nursing Services

Coverage is available to a Plan Participant for Private Duty Nursing Services when performed on an Inpatient and/or Outpatient basis and when the nurse is not related to the Plan Participant by blood, marriage or adoption.

Private Duty Nursing Services are covered at the applicable Coinsurance level shown in the Schedule of Benefits.

O. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional claims are eligible for coverage. Only sleep studies performed in the home or in a network-accredited sleep laboratory are eligible for coverage. Plan Participants should check their provider directory or contact a customer service representative at the number listed on his ID card to verify that a sleep laboratory is accredited.

P. Vision Care - All Benefit Categories

1. One (1) routine eye examination as shown in the Schedule of Benefits.

2. A Plan Participant must pay the Vision Care Copayment shown in the Schedule of Benefits.

ARTICLE XV. CARE MANAGEMENT

A. Selection of Provider, Penalties for Failure to Obtain Authorization, and Authorization of Admissions, Outpatient Services, Other Covered Services and Supplies

1. Selection of Provider

   A Plan Participant may generally obtain medical care from any Provider. Benefits will be paid at the highest Network level when care is received from a Network Provider. Participating and Non-Participating Providers are Non-Network Providers.

   a. If a Plan Participant wants to receive services from a Non-Network Provider and obtain the highest level of Benefits, he must notify the Claims Administrator's Care Management Department before services are rendered. The Claims Administrator will approve the use of a Non-Network Provider only if the Claims Administrator determines that the services cannot be provided by a Network Provider within a seventy-five (75) mile radius of the Plan Participant's home.

      The Claims Administrator must approve the use of the Non-Network Provider and issue any required Authorization before services are rendered. If the Claims Administrator does not approve use of the Non-Network Provider and issue an Authorization prior to services being rendered, Covered Services that are later determined to be Medically Necessary will be paid at the lower Non-Network Level as shown on the Schedule of Benefits.

   b. If the Claims Administrator does approve the use of a Non-Network Provider, that Provider may or may not accept the Plan Participant's Inpatient Hospital Copayment Amount at the time services are rendered. The Plan will pay Benefits up to the Allowable Charge for Covered Services rendered by an approved Non-Network Provider who has obtained any required Authorizations prior to services being rendered. The Claims Administrator will deduct from payment the amount of the Plan Participant's Inpatient Hospital Copayment, whether or not the Copayment is accepted by the Non-Network Provider.

   An Authorization of Medical Necessity is not an approval of the use of a Non-Network Provider. These are two separate functions.

2. Penalties for Failure to Obtain Authorization – Admissions, Outpatient Services and Other Covered Services

   If Authorization is not requested prior to Admission or receiving Outpatient services requiring an Authorization, the Plan will have the right to determine if the Admission or Outpatient services were Medically Necessary. If determined not Medically Necessary, the Admission or Outpatient services and supplies will not be covered and the Plan Participant must pay all charges incurred.

   If the Admission or Outpatient services were Medically Necessary, Benefits will be provided based on the Network status of the Provider rendering the services, as follows.

   a. Admissions

      (1) If a Network Provider or a Participating Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider or Participating Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Copayment or Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

      (2) If a Non-Participating Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the amount shown in the Schedule of Benefits. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for the penalty amount.

(3) The Plan Participant remains responsible for his Inpatient Hospital Copayment Amount, or any applicable Deductible amount and Coinsurance percentage.

b. Outpatient Services, Other Covered Services and Supplies

(1) If a Network Provider fails to obtain a required Authorization, We may reduce the Allowable Charge by the amount shown in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Network Provider is responsible for all charges not covered.

(2) If a Non-Network Provider fails to obtain a required Authorization, the Plan will reduce Allowable Charges by the amount shown in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Plan Participant is responsible for all charges not covered and for the penalty amount.

(3) The Plan Participant remains responsible for any applicable Copayment amount, or any applicable Deductible amount and Coinsurance percentage.

(4) If a service or supply was not Medically Necessary, the service or supply is not covered.

3. Authorization of Admissions

a. Authorization of Elective Admissions

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

(1) If a request for Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission is not covered and the Plan Participant must pay all charges incurred during the Admission for which Authorization was denied.

(2) If Authorization is not requested prior to an Admission, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.

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

b. Authorization of Emergency Admissions

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

be determined by the Claims Administrator when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission will not be covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission for which the Authorization was denied.

(2) If Authorization is not requested, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.

(3) Additional amounts for which the Plan Participant is responsible because Authorization of an Emergency Admission was denied or not requested are considered non-covered and will not apply toward the Out-of-Pocket Amount.

c. Concurrent Review

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

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

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

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

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

Certain services, supplies, and Prescription Drugs require the Claims Administrator's Authorization before a Plan Participant receives the services, supplies, or Prescription Drugs. The Authorizations list is shown in the Plan Participant's Schedule of Benefits. The Plan Participant is responsible for making sure his Provider obtains all required Authorizations for him before he receives the services, supplies, or Prescription Drugs. The Claims Administrator may need the Plan Participant's Provider to submit medical or clinical information about the Plan Participant's condition. To obtain Authorizations, the Plan Participant's Provider should contact the Claims Administrator's Care Management Department at the telephone number shown on the Plan Participant's ID card.

a. If a request for Authorization is denied by the Claims Administrator, the Outpatient services and supplies are not covered.

b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, the Plan will have the right to determine if the services and supplies were Medically Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider.

c. Additional amounts for which the Plan Participant is responsible because Authorization of Outpatient services and supplies was denied or not requested are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

5. Appeals

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

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

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

B. Disease Management

1. Qualification

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

2. Disease Management Benefits

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

C. Case Management

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

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

3. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Case Management services will not obligate the Claims

Administrator to make the same or similar determination for any other Plan Participant. The provision of Case Management services to one Plan Participant will not entitle any other Plan Participant to Case Management services or be construed as a waiver of the Claims Administrator's right, to administer and enforce this Benefit Plan in accordance with its express terms.

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

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

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

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

D. Alternative Benefits

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

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

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

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

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

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

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

ARTICLE XVI. LIMITATIONS AND EXCLUSIONS

A. Services, supplies and treatment for services that are not covered under this Plan and complications from services, supplies and treatment for services that are not covered under this Plan are excluded.

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

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

2. Any charges exceeding the Allowable Charge.

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

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

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

   b. rendered or furnished before a Plan Participant's Effective Date. Charges for Hospital services or supplies rendered or furnished during an Admission in progress on a Plan Participant's Effective Date are not covered until 12:01 AM of the Plan Participant's Effective Date unless otherwise required by law. An Admission in progress on the date the Plan Participant's coverage under this Benefit Plan ends will be covered until the date that coverage ends. The Plan Participant will not receive Benefits for any charges incurred after the date coverage ends;

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

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

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

   f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures for such determinations which are on file with the Louisiana Department of Insurance;

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

   h. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; or

   i. ordered, prescribed or rendered by a Provider who is related to a Plan Participant by blood, marriage or adoption, or who regularly resides in a Plan Participant's household.

5. Services in the following categories:

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

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

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

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

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

6. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**

a. rhinoplasty;

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

c. gynecomastia;

d. breast enlargement, except for breast reconstructive services as specifically provided in this Benefit Plan, or breast reduction, unless determined to be Medically Necessary and as specifically provided in this Benefit Plan;

e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants;

f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;

g. diastasis recti;

h. biofeedback;

i. lifestyle/habit changing clinics and/or programs, except those offered, endorsed, approved, or promoted by the Plan Administrator, which may be part of your health care coverage under this Benefit Plan, or which may be a value-added program subject to minimal additional cost to You, should You voluntarily choose to participate in the program;

j. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies;

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

l. recreational therapy;

m. primarily to enhance athletic abilities and/or

n. Inpatient pain rehabilitation and pain control programs

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

a. eyeglasses or contact lenses (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery);

b. eye exercises, visual training, or orthoptics;

c. hearing aids or for examinations for the prescribing or fitting of hearing aids;

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

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

f. visual therapy.

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

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

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

   c. the transplant of any non-human organ or tissue; or

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

9. Regardless of Medical Necessity, Benefits are not available for any of the following, except as specifically provided for in this Benefit Plan:

   a. weight reduction programs;

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

   c. Services, Surgery, supplies or treatment for obesity or morbid obesity. However, Benefits will be provided for Surgery and services related to the Surgery for morbid obesity which is defined as a body mass index (BMI) greater than forty (40) or a BMI greater than thirty-five (35) with co-morbidities of clinically significant coronary artery disease, adult onset diabetes mellitus, hypertension (uncontrolled blood pressure greater than one hundred-fifty (150) systolic or ninety (90) diastolic) or major joint disease, which is attributable to the obesity.

      Other services and/ or supplies for obesity and morbid obesity are not covered.

10. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings.

11. Prescription Drugs other than those administered during an Inpatient or Outpatient stay or those requiring parental administration in a Physician’s office. The following Prescription Drugs are also excluded:

    a. Any medication not proven effective in general medical practice.

    b. Investigational drugs and drugs used other than for the FDA approved indication, except drugs prescribed for the treatment of cancer that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug.

    c. Fertility drugs.

    d. Minerals and vitamins, except for vitamins requiring a prescription for dispensation and administered during a hospital stay or in a Physician's office.

    e. Nutritional or dietary supplements, or herbal supplements and treatments.

    f. Prescription Drugs related to a non-covered service.

g. Medication, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner.

h. Prescription Drugs for and/or treatment of idiopathic short stature.

See the Schedule of Benefits for additional information regarding Prescription Drug coverage, limitations and/or exclusions.

12. Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider.

    Covered Prescription Drugs that typically require administration by a healthcare professional are covered under the medical benefit when obtained from a healthcare professional.

13. Sales tax or interest.

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

15. Telemedicine rendered by a Non-Network Provider, unless approved by the Claims Administrator, and telephone conversations or electronic mail messaging between any Provider and a Plan Participant are not Covered Services.

16. Charges for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

17. Routine foot care; palliative or cosmetic care or treatment; treatment of flat feet. Except for persons who have been diagnosed with diabetes: cutting or removal of corns and calluses, nail trimming or debriding, or supportive devices of the foot.
18. Any abortion other than to save the life of the mother or if pregnancy is the result of rape or incest.

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

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

21. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.

22. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.

23. Cosmetic Surgery, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly. Complications resulting from any of these or any other non-covered items are excluded.

24. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits. This exclusion does not apply to cleft lip and cleft palate coverage

25. Diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition. This exclusion does not apply to cleft lip and cleft palate coverage

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

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

28. Educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This exclusion for educational services and supplies does not apply to training and education for diabetes.

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

30. Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.

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

32. Hospital charges for a well newborn.

33. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.

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

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

36. Paternity tests and tests performed for legal purposes.

37. Reversal of a voluntary sterilization procedure.

38. Services, Surgery, supplies, treatment, or expenses of a covered Plan Participant related to:

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

    b. pre-implantation genetic diagnosis;

    c. preconception carrier screening; and

    d. prenatal carrier screening except screenings for cystic fibrosis.

39. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by Us.

40. Any services, supplies or treatment for complications resulting from non-covered services, except from a non-covered abortion.

41. Speech Therapy, except when performed by a speech therapist and ordered by a Physician for:

    a. Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); or

    b. an injury; or

c. a sickness that is other than a learning or Mental Disorder.

42. Sleep studies, unless performed in the home or in a network-accredited sleep laboratory. If a sleep study is performed in a sleep laboratory that is not network-accredited, or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.

43. Applied Behavior Analysis (ABA) that the Company has determined is not Medically Necessary. ABA rendered to Plan Participants age seventeen (17) and older. ABA rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

ARTICLE XVII. CONTINUATION OF COVERAGE RIGHTS

A. Leave of Absence

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

   a. An Employee who is granted leave of absence without pay due to a service related injury may continue coverage and the Employer shall continue to pay its portion of health plan premiums for up to twelve (12) months if the Employee continues his coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

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

   c. An Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the Employer shall continue to pay its portion of premiums if the Employee continues his coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

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

   An Employee granted leave of absence without pay for reasons other than those stated in above in paragraph a, may continue to participate in this Benefit Plan for a period up to twelve (12) months upon the Employee's payment of the full premiums due.

B. Surviving Spouse/Dependents Continuation

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

   a. The surviving Spouse of an Employee or Retiree may continue coverage unless or until the surviving Spouse is or becomes eligible for coverage under a group health plan other than Medicare or until attainment of the termination age for Children, whichever occurs first.

   b. The surviving Dependent Child of an Employee or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a group health plan other than Medicare, or until end of the month of the attainment of the termination age for that specific Dependent Child, whichever occurs first.

   c. Surviving Dependents will be entitled to receive the same Group premium contributions as Employees and Retirees, subject to the provisions of La. R.S. 42:851 and rules promulgated pursuant thereto by the Office of Group Benefits.

d. Coverage provided by the Civilian Health and Medical Program of the Uniform Services (CHAMPUS/TRICARE) or successor will not be sufficient to terminate the coverage of an otherwise eligible surviving Spouse or a Dependent Child.

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

2. Employer and Dependent Responsibilities

a. It is the responsibility of the surviving covered Dependent to notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree.

b. The Plan Administrator will notify the surviving Dependents of their right to continue coverage.

c. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of notification, and premium payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.

3. Coverage for the surviving Spouse under this section will continue until the earliest of the following events:

a. Failure to pay the applicable premium timely.

b. Eligibility of the surviving Spouse under a group health plan other than Medicare.

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

a. Failure to pay the applicable premium timely.

b. Eligibility of the surviving Dependent Child for coverage under any group health plan other than Medicare.

c. The end of the month of the attainment of the termination age for that specific Dependent Child.

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

C. Over-Age Dependents

If a Dependent Child is incapable (and became incapable prior to attainment of age twenty-six (26)) of self-sustaining employment, the coverage for the Dependent Child may be continued for the duration of incapacity.

a. Prior to the Dependent Child reaching age twenty-six (26), an application for continued coverage, with current medical information from the Dependent Child's attending Physician along with the Child's attending Physician's attestation of the Child's incapacity to perform self-sustaining employment, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.

b. Upon receipt of the application for continued coverage and Physician's attestation, the Plan Administrator may require additional medical documentation regarding the Dependent Child's incapacity as often as it may deem necessary as a precondition to continue coverage.

D. Military Leave

Employees in the National Guard or in the United States military reserves who are called to active military duty and their covered eligible Dependents will have access to continued coverage under this Benefit Plan subject to submittal of appropriate documentation to the Plan Administrator.

When an Employee is called to active military duty, the Employee and their covered eligible Dependents may:

a. continue participation in the Plan during the period of active military service, in which case the Employer may continue to pay its portion of premiums; or

b. cancel participation in the Plan during the period of active military service, in which case the Employee may apply for reinstatement of coverage within thirty (30) days of:

(1) the date of the Employee's re-employment with the Employer; or

(2) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Employees who elect this option and timely apply for reinstatement coverage, the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding rules promulgated by the Office of Group Benefits.

E. COBRA Continuation

During the period of continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Employees, Retirees and their Dependents.

1. Employees

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

b. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification, and premium payment must be made within forty-five (45) days of the date the Employee elects continued coverage. Coverage will be retroactive to the date it would have otherwise terminated.

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

2. Surviving Dependents

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

b. It is the responsibility of the surviving covered Dependent to notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree. The Plan Administrator will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must

be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification.

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

3. Ex-Spouse/Ex-Stepchildren – Divorce, Annulment or Legal Separation

a. Coverage under this Plan for an Employee's or Retiree's Spouse (and any stepchildren enrolled in the Plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment, or legal separation from the Employee or Retiree, unless the covered ex-Spouse elects to continue coverage at his own expense.

b. It is the responsibility of the Employee / Retiree to notify the Plan Administrator of the divorce, annulment, or legal separation within sixty (60) days from the date of the divorce, annulment, or legal separation. The Plan Administrator will notify the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the election notification.

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

4. Dependent Children

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

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

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

5. Dependents of COBRA Participants

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

(1) Death of the Employee,

(2) Divorce, Annulment, or Legal Separation from the Employee, or

(3) A Dependent Child no longer meets the definition of an eligible covered Dependent, then, the Spouse and/or Dependent child may elect to continue COBRA coverage at his own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

b. It is the responsibility of the Spouse and/or the Dependent Child to notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.

c. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

6. Disability COBRA

a. If a Plan Participant is determined by the Social Security Administration or by the Plan Administrator staff (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient quarters of employment) to have been totally disabled on the date the Plan Participant became eligible for continued coverage or within the initial eighteen (18) months of continued coverage, coverage under this Plan may be extended at his own expense up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated.

b. To qualify for disability COBRA, the Plan Participant must:

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

(a) The date of issuance of the Social Security Administration's disability determination; or

(b) The date on which the qualified beneficiary loses (or would lose) coverage under terms of the Plan as a result of the covered Employee's termination or reduction of hours.

(2) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of employment, submit proof of total disability to the Plan Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the Plan Administrator will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history and other relevant evidence presented by the applicant.

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

d. Monthly payments for each month of extended disability COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

7. Medicare COBRA

a. If an Employee becomes entitled to Medicare less than eighteen (18) months before the date the Employee's eligibility for Benefits under this Plan terminates, coverage under this Plan may be extended at his own expense up to a maximum of thirty-six (36) months.

b. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

8. COBRA continuation coverage will continue until the earliest of the following:

   a. Employees

      (1) Failure to pay the applicable premium timely;

      (2) Eighteen (18) months beyond the date coverage would have otherwise terminated;

      (3) Entitlement to Medicare;

      (4) Coverage under a group health plan; or

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

   b. Surviving Dependents, Divorced Spouse, Dependent Children and Dependents of COBRA Participants

      (1) Failure to pay the applicable premium timely;

      (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

      (3) Entitlement to Medicare;

      (4) Coverage under a group health plan; or

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

   c. Disability COBRA

      (1) Failure to pay the applicable premium timely;

      (2) Twenty-nine (29) months from the date coverage would have otherwise terminated;

      (3) Entitlement to Medicare;

      (4) Coverage under a group health plan; or

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

      (6) Thirty (30) days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Plan Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the Plan Administrator determines that the Covered Person is no longer disabled.

   d. Medicare COBRA

      (1) Failure to pay the applicable premium timely;

      (2) Thirty-six (36) months from the date of the Employee’s Medicare entitlement;

      (3) Entitlement to Medicare;

      (4) Coverage under a group health plan; or

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

ARTICLE XVIII. TERMINATION OF COVERAGE

1. Termination of Coverage

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

   a. The date the Plan terminates;

   b. The date contribution is due if the Plan Participant fails to make any contribution which is required for the continuation of coverage;

   c. The last day of the month of the Plan Participant's death;

   d. The last day of the month in which the Plan Participant ceases to be eligible as an Employee/Retiree or Dependent.

ARTICLE XIX. COORDINATION OF BENEFITS

A. Applicability

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

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

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

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

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

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

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

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

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

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

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

e. Medicare as permitted by federal law;

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

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

Each plan or other arrangement for coverage is a separate plan. If an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is a separate plan.

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

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

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

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

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

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

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

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

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

C. Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

(1) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the calendar year; but

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

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

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

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

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

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

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

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

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

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

(1) First, the benefits of a plan covering the person as an employee, Plan Participant or Subscriber (or as that person's Dependent);

(2) Second, the benefits under the continuation coverage.

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

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

D. Effects on the Benefits of this Plan

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

2. Reduction in This Plan's Benefits

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

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

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

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

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

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

G. Right of Recovery

If the amount of the payments made more than should have been paid under this COB section, We may recover the excess. We may get such recovery or payment from one or more of:

1. The persons the Group has paid or for whom the Group has paid;

2. Insurance companies; or

3. Other organizations.

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

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

ARTICLE XX. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP AND ALL PLAN PARTICIPANTS. THE GROUP IS THE PLAN SPONSOR FOR THIS PLAN.

A. The Benefit Plan

1. Except as specifically provided herein, this Benefit Plan will not make the Claims Administrator liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations.

    a. To the extent this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the Plan Administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those specifically undertaken by Us herein.

    b. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group's failure to do so.

    c. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to Plan Participants for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or in the case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition.

2. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.

3. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.

4. The (Plan Administrator) shall administer the Benefit Plan in accordance with its terms and establishes its policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its employees and Dependents, to decide disputes which may arise relative to a Subscriber's rights, and to decide questions of plan interpretation and those of fact relating to the plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, health care Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

B. Amending and Terminating the Benefit Plan

The Employer intends to maintain this Plan indefinitely; however, it reserves its right, at any time, to amend, suspend or terminate the plan in whole or in part. This includes amending the Benefits under the plan or the trust agreement, if any.

C. Identification Cards and Benefit Plan

The Claims Administrator will prepare an identification (ID) card for each covered Employee. The Claims Administrator will issue a Benefit Plan to the Group and print a sufficient number of copies of this Benefit Plan for the Group's covered Employees. At the direction of Group, the Claims Administrator will either deliver all materials to the Group for Group's distribution to the covered Employees, or the Claims Administrator will deliver the materials directly to each covered Employee. Unless otherwise agreed between the Group and the Claims Administrator, the Group has the sole responsibility for distributing all such documents to covered Employees.

D. Benefits to Which Plan Participants are Entitled

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

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

E. Filing of Claims

1. A Claim is a written or electronic proof of charges for Covered Services that a Plan Participant has incurred during the time period he was covered under this Benefit Plan. We encourage Providers to file Claims in a form acceptable to Us within ninety (90) days from the date services are rendered, but no later than fifteen (15) months after the date of service. Benefits will be denied for Claims filed any later than fifteen (15) months from the date of service. Benefit Plan provisions in effect at the time the service or treatment is received shall govern the processing of any Claim expense actually incurred as a result of the service or treatment rendered.

F. Applicable Law

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

G. Legal Action

No lawsuit may be filed:

- Any earlier than the first sixty (60) days after notice of Claim has been given; or

- Any later than fifteen (15) months after the date services are rendered.

H. Release of Information

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

I. Assignment

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

2. The Plan reserves the right to pay HMOLA Network Providers and/or Participating Providers directly instead of paying the Plan Participant.

J. Plan Participant/Provider Relationship

1. The choice of a Provider is solely the Plan Participant's.

2. The Claims Administrator and all network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. The Claims Administrator does not render Covered Services, but only makes payment, on behalf of the Plan, for Covered Services for which the Plan Participant receives. Neither the Plan nor the Claims Administrator will be held liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any network Provider or in any network Provider's facilities. The Plan and the Claims Administrator have no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.

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

K. This Benefit Plan and Medicare

1. For Employers having twenty (20) or more active Employees, federal law and regulations require that each active Employee age sixty-five (65) or older, and each active Employee's spouse age sixty-five (65) or older, may elect to have coverage under this Plan or under Medicare.

    a. Where such Employee or such spouse elects coverage under this Plan, this Plan will be the primary payor of Benefits with the Medicare program the secondary payor.

    b. This Plan will not provide Benefits to supplement Medicare payments for Medicare eligible expenses for an active Employee age sixty-five (65) or older or for a spouse age sixty-five (65) or older of an active Employee where such Employee or such spouse elects to have the Medicare program as the primary payor.

2. Under federal law, if an active Employee under age sixty-five (65) or an active Employee's Dependent under age sixty-five (65) is covered under a group Benefit Plan of an employer with one hundred (100) or more Employees and also has coverage under the Medicare program by reason of Social Security disability, the Group Benefit Plan is the primary payor and Medicare is the secondary payor.

3. For persons under age sixty-five (65) who are covered under this Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Plan the secondary payor, except that during the first thirty (30) month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, this Plan will be the primary payor and Medicare the secondary payor.

4. When this Plan is the primary payor, it will provide regular Benefits for Covered Services.

    When this Plan is the secondary payor, it will provide Benefits based on the lesser of: the Medicare approved amount or Our Allowable Charge. When an Allied Provider or Physician is not required by

Medicare to accept the Medicare approved amount as payment in full, the Plan will base Benefits on the lesser of: the Medicare approved amount plus Medicare's limiting charge, if applicable, or the Claims Administrator's Allowable Charge.

L. Notice

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

M. Job-Related Injury or Illness

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

N. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Group will be subrogated and will succeed to the Plan Participant's right for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier even where such carrier provides Benefits directly to a Plan Participant who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights.

2. The Plan Participant will reimburse the Plan all amounts recovered by suit, settlement, or otherwise from any third party or the Plan Participant's insurer to the extent of the Benefits provided or paid under this Plan. The Plan's right to reimbursement comes first even if the Plan Participant is not paid for all of the Plan Participant's Claim for damages against the other person or organization or even if the payment the Plan Participant receives is for, or is described as for, the Plan Participant's damages other than health care expenses, or if the Plan Participant recovering the money is a minor. All costs that the Plan Participant incurs (including attorney fees) in exercising any right of recovery will be the Plan Participant's responsibility. Amounts that the Plan paid for which a third party or insurer is responsible will not be reduced by the amount of the Plan Participant's costs. The Plan Participant shall hold in trust for the account of the Plan all amounts recovered, up to the total amount of Benefits paid. The Group appoints the Plan Participant as its representative for such limited purpose only.

3. The Plan Participant will take such action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of the Group's rights, and will take no action prejudicing the Group's rights and interest under this Plan. The Plan and its designees have the right to obtain and review Plan Participant's medical and billing records, if the Plan or its designee determines in their sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits Article of this Benefit Plan.

4. The Plan Participant will notify the Benefit Plan of any Accidental Injury.

O. Right of Recovery

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

P. Coverage in a Department of Veterans Affairs or Military Hospital

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from the Plan to the extent the veteran would be eligible for Benefits for such care or services from the plan if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

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

Q. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Blue Cross and Blue Shield of Louisiana to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Plan Administrator, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than HMO Louisiana, Inc. and that no person, entity, or organization other than HMO Louisiana, Inc. shall be held accountable or liable to the Plan Administrator for any of Our obligations to the Plan. This paragraph shall not create any additional obligations whatsoever on the part of HMO Louisiana, Inc. other than those obligations created under other provisions of the plan administration agreement.

R. Out-of-Area Services

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

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

1. BlueCard® Program

   Under the BlueCard® Program, when Plan Participants access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever Plan Participants access Covered Services outside Blue Cross and Blue Shield of Louisiana's service area and the Claim is processed through the BlueCard® Program, the amount Plan Participants pay for Covered Services from Participating Providers is calculated based on the lower of:

- the billed charges for your Covered Services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

2. Medicare Supplemental/Medigap/Medicare Complementary

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

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

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

   When covered healthcare services are provided outside of Blue Cross and Blue Shield of Louisiana's service area by Non-Participating Providers, the amount Plan Participant pays for such services is described below.

   a. Plan Participant Liability Calculation

      When Covered Services are provided outside of Blue Cross and Blue Shield of Louisiana's service area by Non-Participating Providers, the amounts a Plan Participant pays for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Plan Participant may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Claims Administrator will make for the Covered Services as set forth in this paragraph.

   b. Exceptions

      In some exception cases, Claims Administrator may pay claims from Non-Participating Providers outside of Blue Cross and Blue Shield of Louisiana's service area based on the provider's billed charge, the payment Claims Administrator would make if it were paying a non-participating provider

inside of its service area (where the Host Blue's corresponding payment would be more than the Company's in-service area Non-Participating Provider payment), or in the Claims Administrator's sole and absolute discretion, it may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Plan Participant may be responsible for the difference between the amount that the Non-Participating Provider bills and payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

c. Medigap/Medicare Supplemental/Medicare Complementary Plans

Under Medigap/Medicare Supplemental/Medicare Complementary plans, when Plan Participant receives treatment from a healthcare provider that does not participate with the Host Blue, but does accept Medicare assignment, the amount Plan Participant pays for services otherwise covered by the federal Medicare Program will be calculated based on the Medicare allowable amount. If the healthcare provider does not accept Medicare assignment, Plan Participant may be liable for the difference between the amount that the provider bills and the Medicare limiting charge, which will include the payment Claims Administrator will make for the covered services as set forth in this paragraph. If Plan Participant has additional Benefits for healthcare services which Medicare would not otherwise cover, the amount Plan Participant pays for such services provided by a healthcare provider not participating with the Host Blue will be calculated based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, Plan Participant may be liable for the difference between the amount that the Non-Participating healthcare provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph.

4. Out-of-Area Claims: Plan Participant Liability Calculation – Emergency Care from Non-Participating Providers

If You need Emergency Medical Services in the emergency department of a Hospital, You will be covered at the highest level that the Patient Protection and Affordable Care Act and federal regulations require. You will have to pay for any charges that exceed the Allowable Charge as well as any Deductibles, Coinsurance and Copayments.

S. Certificates of Creditable Coverage

The Claims Administrator will issue a certificate of Creditable Coverage or similar document to a Plan Participant, if requested within twenty-four (24) months after coverage under this Benefit Plan ceases.

T. Compliance with HIPAA Privacy Standards

Certain Employees of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards of Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access subject to the following:

1. General

The Plan shall not disclose Protected Health Information to any Employees of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

Protected Health Information disclosed to Employees of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health

care operations" shall have the same definitions as set out in the Privacy Standards, the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of Benefits or reimbursement for health care. "Health Care Operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

3. Authorized Employees

The Plan shall disclose Protected Health Information on to Employees of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "Employees of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer.

a. Updates Required. The Employer shall amend the plan promptly with respect to any changes in the Employees of its workforce who are authorized to receive Protected Health Information.

b. Use and Disclosure Restricted. An authorized Employee of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

c. Resolution of Issues of Noncompliance. In the event that any Employee of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

(1) investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;

(3) mitigating any harm caused by the breach, to the extent practicable; and

(4) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Employer

The Employer must provide certification to the Plan that it agrees to:

a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Employer;

d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. ensure the adequate separation between the Plan and Employee of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

The following Employees of the East Baton Rouge Parish School System workforce are designated as authorized to receive Protected Health Information from East Baton Rouge Parish School System ("the Plan") in order to perform their duties with respect to the Plan:

Chief Business Operations Officer, General Counsel, Director of Finance, Chief Accountant, Budget Analyst, Supervisor of Payroll/Benefits, Supervisor of Accounting, Grants Fiscal Officer, Staff Accountant, Grants Specialist IV, Finance Specialist IV, Budget Specialist, Administrative Secretary, Finance Specialist III, Finance Specialist II, Payroll/Benefits Specialist II, Finance Specialist I, Benefits Specialist I, Accounting Specialist I and Insurance Consultant/Broker.

U. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections (3) Authorized Employees and (4) Certification of Employers described above in this Article.

ARTICLE XXI. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The Claims Administrator wants to know when a Plan Participant is unhappy about quality of the care or services they receive from the Claims Administrator or one of Our Providers. Plan Participants may register a Complaint or file a formal written Grievance about the Claims Administrator or a Provider by following the procedures outlined below.

Appeal rights for Plan Participants are outlined after the Complaint and Grievance Procedures. The Plan considers a Plan Participant's request to change a coverage decision as an Appeal. An Appeal is defined as a request from a Plan Participant or their authorized representative to change a previous decision made by the Claims Administrator about Covered Services. Examples of issues that qualify as Appeals include denied Authorizations, Claims denied based on Adverse Determinations of Medical Necessity, or other Adverse Determinations of Benefits.

In addition to the right to Appeal, the Plan Participant's Provider is given an opportunity to speak with a Medical Director for Informal Reconsideration of the Claims Administrator's coverage decisions concerning Medical Necessity or Investigational determinations.

The Plan Participant may also have the right to review their file and present evidence or testimony as part of the internal Claims and Appeals process.

An Expedited Appeal process is available for situations where the time frame of a standard Appeal would seriously jeopardize the life or health of a covered person, jeopardize the covered person's ability to regain maximum function, or where in the opinion of the treating Physician, the covered person may experience pain that cannot be adequately controlled while awaiting a standard Appeal decision.
The Claims Administrator will respond to your Appeal request within the timeframes allowed by law. The Appeal response will provide information sufficient to identify the Claim and include the following:

- The date of service; health care Provider; Claim amount, if applicable; and diagnosis and treatment codes (the corresponding meanings of these codes will be provided upon request).

- A description of the reason(s) for the denial, including a description of the standard, if any, applied in denying the Claim (for example, if a Medical Necessity standard was used in denying a Claim, the notice will describe the Medical Necessity standard); and a discussion of the decision for Benefit denials.

- A description of available internal Appeals and External Appeal procedures, including information on how to initiate an Appeal.

- Contact information for available sources to assist Plan Participants with internal Appeals and External Appeal procedures.

A. Complaint and Grievance Procedures

A quality of service concern addresses the Claims Administrator's services, access, availability or attitude and those of the Claims Administrator's Network Providers. A quality of care concern addresses the appropriateness of care given to a Plan Participant.

1. To Register a Complaint

   A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Call the Claims Administrator's customer service department at 1-800-376-7741 or 1-293-0625 to register a Complaint. The Claims Administrator will attempt to resolve a Plan Participant's Complaint at the time of their call.

2. To File a Formal Grievance

   A Grievance is a written expression of dissatisfaction with the Claims Administrator or with services rendered by a Provider. If a Plan Participant does not feel their Complaint was adequately resolved or the Plan Participant wishes to file a formal Grievance, the Plan Participant must submit this in writing

within 180 days of the event that led to the dissatisfaction. The Claims Administrator's customer service department will assist the Plan Participant if necessary. Send written Grievances to:

HMO Louisiana, Inc.
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

A response will be mailed to the Plan Participant within thirty (30) business days after the Claims Administrator receives the written Grievance.

3. Informal Reconsideration

An Informal Reconsideration is an authorized Provider's telephone request to speak to the Claims Administrator's Medical Director or a peer reviewer on the Plan Participant's behalf about a Utilization Management decision the Claims Administrator has made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

Informal Reconsideration is available only for initial determinations that are requested within ten (10) days of the denial or Concurrent Review determinations. The Claims Administrator will conduct an Informal Reconsideration within one (1) working day of the receipt of the request.

B. Appeal Procedures

Plan Participants are offered two (2) levels of Appeal. The second level of Appeal is voluntary and will be handled by the Group. Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Plan Participant's decision whether or not to submit to this voluntary level of review will have no effect on his rights to any other Benefits under the plan. No fees or costs will be imposed on the Plan Participant.

MULTIPLE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED AT ANY LEVEL OF REVIEW.

If the Plan Participant has questions or needs assistance putting the Appeal in writing, the Plan Participant may call the Claims Administrator's customer service department at 1-800-376-7741 or 1-225-293-0625.

The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

C. Appeal Process

The Claims Administrator will distinguish the Plan Participant's Appeal as either an administrative Appeal or a medical Appeal. Each type of Appeal has two (2) levels, including review by a committee at the second level for administrative Appeals. The second level for medical Appeals is handled by the Plan Administrator, East Baton Rouge Parish School System. Plan Participants are encouraged to submit written comments, documents, records, and other information relating to the Claim for Benefits. Upon request by the Plan Participant and free of charge, the Claims Administrator will provide reasonable access to and copies of all documents, records, and other information relevant to the Plan Participant's Claim for Benefits.

The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in their Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in an Appeal of an Adverse Determination. The authorized representative may be the Plan Participant's treating Provider, if the Plan Participant appoints the Provider in writing. The Provider must agree and waive, in writing, any right to payment from the Plan Participant other than any applicable Copayment, Deductible and/or Coinsurance amount.

Persons not involved in the previous decision regarding the Plan Participant's Claim will decide all Appeals. A Physician or other health care professional; in the same or an appropriate specialty that typically

manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the Plan Participant's Claim, will review Medical Necessity Appeals.

1. Administrative Appeals

   Administrative Appeals involve contractual issues other than Medical Necessity or Investigational denials and those denials that do not require medical judgment. Examples include Adverse Determinations based on Benefit Plan limitations or exclusions and Rescissions of coverage. Administrative Appeals should be submitted in writing to:

   HMO Louisiana, Inc.
   Appeals and Grievance Unit
   P. O. Box 98045
   Baton Rouge, LA 70898-9045

   a. First Level Administrative Appeals

      If the Plan Participant is not satisfied with the Claims Administrator's denial of services, the Plan Participant, his authorized representative, or a Provider authorized to act on the Plan Participant's behalf, must submit a written request to Appeal within one hundred eighty (180) days following receipt of an initial Adverse Determination. Requests submitted to the Claims Administrator after one hundred eighty (180) days of the initial denial will not be considered.

      The Claims Administrator will investigate the Plan Participant's concerns. If the original decision is changed at the Appeal level, the Claims Administrator will process the Plan Participant's Claim and notify the Plan Participant and all appropriate Providers, in writing, of the first level administrative Appeal decision. If the Plan Participant's Claim is denied on Appeal, the Claims Administrator will notify the Plan Participant and all appropriate Providers, in writing, of the decision within thirty (30) calendar days of the Plan Participant's request, unless We mutually agree that an extension of the time is warranted. At that time, the Claims Administrator will inform the Plan Participant of the right to begin the second level administrative Appeal process.

   b. Second Level Administrative Appeals

      Not applicable to a Rescission of coverage Appeal, which follows the External Appeals track.

      Within sixty (60) calendar days of the date of the first level administrative Appeal decision, a Plan Participant who is not satisfied with the decision may initiate, with assistance from the customer service department, if necessary, the second level of administrative Appeal process. Requests submitted to the Claims Administrator after sixty (60) days of the denial will not be considered.

      A Plan Participant Appeals Committee not involved in any previous denial will review all second level administrative Appeals. The Committee's decision is final and binding as to any administrative Appeal and will be mailed to the Plan Participant within five (5) days of the Committee meeting.

2. Medical Appeals

   Medical Appeals involve a denial or partial denial of services based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or when a service is determined to be experimental or Investigational.

   a. First Level Internal Appeals

      If the Plan Participant is not satisfied with the Claims Administrator's denial of services, the Plan Participant, their authorized representative, or a Provider acting on their behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Plan Participant's receipt of an initial Adverse Determination. Medical Appeals should be submitted in writing to:

HMO Louisiana, Inc.
Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

Requests submitted to the Claims Administrator after one hundred eighty (180) days of the denial will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. All internal medical Appeals will be reviewed by a Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. If the initial denial is overturned on the Plan Participant's medical Appeal, the Claims Administrator will process the Claim and will notify the Plan Participant and all appropriate Providers, in writing, of the internal Appeal decision. If the initial denial is upheld, the Claims Administrator will notify the Plan Participant and all appropriate Providers, in writing, of the decision and advise the Plan Participant of their right to request an External Appeal. The decision will be mailed within thirty (30) days of the Plan Participant's request, unless the Plan Participant, their authorized representative and the Claims Administrator mutually agree that an extension of the time is warranted. At that time, the Claims Administrator will inform the Plan Participant of their right to begin the External Appeal process if the Claim meets the criteria.

b. Second Level External Appeals

First level internal Appeal must be exhausted before the Plan Participant has a right to request an External Appeal. If the Plan Participant disagrees with the internal Appeals determination, the Plan Participant or their authorized representative may request an External Appeal conducted by a non-affiliated Independent Review Organization (IRO). Within one hundred twenty (120) days of receipt of the internal Appeal decision, the Plan Participant must send his written request to:

East Baton Rouge Parish School System
Attention: Grievance and Appeals Coordinator
1050 South Foster Drive
Baton Rouge, LA 70806

Requests submitted to the Plan Administrator after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered.

Requests submitted to the Claims Administrator will be forwarded to the East Baton Rouge Parish School System. The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

The Claims Administrator will provide all pertinent information necessary to conduct the External Appeal. The IRO decision will be considered a final and binding decision on both the Plan Participant and the Group. The External Appeal will be completed within forty-five (45) days of receipt of the request and the IRO will notify the Plan Participant or their authorized representative and all appropriate Providers of its decision.

3. Expedited Appeals

a. Expedited Internal Appeals

The Claims Administrator provides an Expedited Appeal process for review of an Adverse Determination involving a situation where the time frame of the standard Appeal would seriously jeopardize the Plan Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard Appeal decision. In these cases, the Claims Administrator will make a decision no later than seventy-two (72) hours of receipt of an Expedited Appeal request that meets the criteria for Expedited Appeal.

An Expedited Appeal is a request concerning an Admission, availability of care, continued stay, or health care service for a Plan Participant who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility. Expedited Appeals are not provided for review of services previously rendered. An Expedited Appeal shall be made available to, and may be initiated by the Plan Participant; the Plan Participant's authorized representative, or the Provider acting on behalf of the Plan Participant. Requests for an Expedited Appeal may be oral or written and should be made to:

HMO Louisiana, Inc.
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022
1-800-376-7741 or 1-225-293-0625

In any case where the internal Expedited Appeal process does not resolve a difference of opinion between the Claims Administrator and the Plan Participant or the Provider acting on his behalf, the Appeal may be elevated to an Expedited External Appeal.

b. Expedited External Appeal

An Expedited External Appeal is a request for immediate review, by an Independent Review Organization (IRO), of an initial Adverse Determination not to Authorize continued services for a Plan Participant currently in the emergency room, under observation in a facility or receiving Inpatient care.

Expedited External Appeals are not provided for review of services previously rendered. An Expedited External Appeal of an Adverse Determination is available if pursuing the standard Appeal procedure could seriously jeopardize the Plan Participant's life, health or ability to regain maximum function; or when in the opinion of the treating physician, the covered person may experience pain that cannot be adequately controlled while waiting for a decision on a second level External Appeal.

An Expedited External Appeal is also available if the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is deemed experimental or Investigational; and the Plan Participant's treating Physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated. The request may be simultaneously filed with a request for a standard internal Expedited Appeal, since the Independent Review Organization assigned to conduct the external review will determine whether the request is eligible for an Expedited External Appeal at the time of receipt.

All pertinent information for Expedited External Appeal requests will be provided so the review may be completed within seventy-two (72) hours of receipt.

4. Binding Nature of External Appeal Decisions

All External Appeal decisions rendered by the IRO are binding on the Plan and the Plan Participant. This Appeals process shall constitute the Plan Participant's sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary, experimental or Investigational, except to the extent that other remedies are available under state or federal law.

ARTICLE XXII. CARE WHILE TRAVELING, MAKING POLICY CHANGES AND FILING CLAIMS

The Claims Administrator is continuing to update its online access for Plan Participants. Plan Participants may now be able to perform many of the functions described below, without contacting the Claims Administrator's customer service department. The Claims Administrator invites Plan Participants to log on to **www.bcbsla.com** for access to these services.

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of the Claims Administrator's local service offices, or from the home office of Blue Cross and Blue Shield of Louisiana. If the Plan Participant needs to submit documentation to the Claims Administrator, the Plan Participant may forward it to HMO Louisiana Inc. at P. O. Box 98024, Baton Rouge, LA70898-9024, or to, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Plan Participant has any questions about any of the information in this section, the Plan Participant may speak to his Employer or call the Claims Administrator's customer service department at the telephone number shown on his ID card.

A. How to Obtain Care While Traveling

The Plan Participant's ID card offers convenient access to PPO health care outside of Louisiana. If the Plan Participant is traveling or residing outside of Louisiana and needs medical attention, please follow these steps:

1. In an Emergency, go directly to the nearest Hospital.

2. Call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest Preferred Network doctors and Hospitals.

3. Use a designated Preferred Network Provider to receive the highest level of Benefits.

4. Present the Plan Participant's ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.

5. The Plan Participant must obtain any required Authorizations from Blue Cross and Blue Shield of Louisiana.

B. Adding or Changing the Plan Participant's Family Plan Participants on the Plan

The Schedule of Eligibility lets the Plan Participant know when it is necessary to enroll additional family members for Dependent coverage under the Plan. Please read the Schedule of Eligibility Article and this section as they contain important information for the Plan Participant.

Group may require the Employee to use the Group Enrollment Change Form to enroll family members not listed on the Plan Participant's original enrollment form. If the Plan Participant does not complete and return a required Group Enrollment Change Form to the Plan so the Claims Administrator receives it within the timeframes set out in the Schedule of Eligibility, it is possible that the Plan Participant's health benefits coverage will not be expanded to include the additional family members. Completing and returning a Group Enrollment Change Form is especially important when the Plan Participant's first Dependent becomes eligible for coverage or when the Plan Participant no longer has any eligible Dependents.

The Schedule of Eligibility explains when coverage becomes effective for new family members. Generally, a Group Enrollment Change Form is used to add newborn children, newborn adopted children, a spouse, or other Dependents not listed on the Plan Participant's original enrollment form. The Plan should receive the Plan Participant's completed form within thirty (30) days of the child's birth or placement, or the Plan Participant's marriage.

C. How to File Claims for Benefits

The Claims Administrator and most Providers have entered into agreements that eliminate the need for a Plan Participant to personally file a Claim for Benefits. Preferred Providers and Participating Providers will file Claims for Plan Participants either by mail or electronically. In certain situations, the Provider may request the Plan Participant to file the Claim. If the Plan Participant's Provider does request the Plan Participant to file directly with the Claims Administrator, the following information will help the Plan Participant in correctly completing the Claim form.

The Plan Participant's ID card shows the way the name of the Employee (Plan Participant of the Group) appears on the Claims Administrator's records. (If the Plan Participant has Dependent coverage, the name(s)

are recorded as shown on the enrollment information the Plan received.) The ID card also lists the Plan Participant's contract number (ID #). This number is the identification to the Plan Participant's membership records and should be provided to the Claims Administrator each time a Claim is filed. To assist in promptly handling the Plan Participant's Claims, the Plan Participant must be sure that:

1. an appropriate Claim form is used

2. the contract number (ID #) shown on the form is identical to the number on the ID card

3. the patient's date of birth is listed

4. the patient's relationship to the Employee is correctly stated

5. all charges are itemized, whether on the Claim form or on the attached statement

6. the itemized statement from the Provider contains the Provider's name, address and tax ID number and is attached to the Claim form

7. the date of service (Admission to a Hospital or other Provider) or date of treatment is correct

8. the Provider includes a diagnosis and procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)

9. the Claim is completed and signed by the Plan Participant and the Provider.

IMPORTANT NOTE: The Plan Participant must be sure to check all Claims for accuracy. The contract number (ID #) must be correct. It is important that the Plan Participant keep a copy of all bills and Claims submitted.

D. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

   When a Plan Participant is being admitted to a Preferred Network Provider or Participating Provider, the Plan Participant should show his Blue Cross and Blue Shield ID card to the admitting clerk. The Provider will file the claim with the Claims Administrator. The Plan's payments will go directly to the Preferred Network Provider or Participating Provider. The Provider will then bill the Plan Participant directly for any remaining balance. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

2. Outpatient Department Claims

   The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility. However, in some instances involving Outpatient treatment, the Provider may ask for payment directly from the Plan Participant. If this occurs, the Plan Participant should obtain an itemized copy of the bill, be sure the Claim form correctly notes the contract number (ID #), the patient's date of birth, as well as the patient's relationship to the Employee. The Provider must mark the statement or Claim form PAID. This statement should then be sent to the Claims Administrator.

3. Emergency Room Claims

   When a Plan Participant has Emergency Room services performed by a Network or Non-Network Provider, the Plan Participant should show their ID card to the admitting clerk. The Provider will file the Claim with Us. Benefit payment will be sent directly to the Provider. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

4. Nursing Services Claims

   A receipt must be obtained for nursing services from each nurse indicating the name of the patient and the number of days covered by each receipt. Each receipt must also be signed by the nurse with the initials RN or LPN and registry number. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary must be filed with the receipts for nursing services.

5. Durable Medical Equipment (DME) Claims

   Charges for rental or purchase of wheelchairs, braces, crutches, etc. must be on the bill of the supplying firm, giving a description of the item rented or purchased, the date, the charge, and the patient's name. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary must also be filed with these bills.

6. Mental Health and/or Substance Abuse Claims

   For help with filing a Claim for Mental Health and/or substance Abuse, the Plan Participant should refer to his ID card or call the Claims Administrator's customer service department.

7. Other Medical Claims

   When the Plan Participant receives other medical services (clinics, Provider offices, etc.), he should ask if the Provider is a Preferred Network Provider or Participating Provider. If yes, this Provider will file the Plan Participant's Claim with the Claims Administrator. In some situations, the Providers may request payment and ask the Plan Participant to file. If this occurs, the Plan Participant must be sure the claim form is complete before forwarding to the Claims Administrator. If the Plan Participant is filing the Claim, the Claim must contain the itemized charges for each procedure or service.

   NOTES: Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills. Itemized bills submitted with Claim forms must include the following:

   a. full name of patient

   b. date(s) of service

   c. description of and procedure code for service

   d. diagnosis code

   e. charge for service

   f. name and address of Provider of service.

E. If Plan Participant Has a Question about His Claim

Plan Participants can view information about the processing or payment of a claim online at **www.bcbsla.com**.

If a Plan Participant has a question about the payment of a Claim, the Plan Participant can write to the Claims Administrator at the address below or the Plan Participant may call the Claims Administrator 's customer service department at the telephone number shown on his ID card or any of the Claims Administrator's local service offices*. If the Plan Participant calls for information about a Claim, the Claims Administrator can help the Plan Participant better if the Plan Participant has the information at hand, particularly the ID number, patient's name and date of service.

HMO Louisiana, Inc.
P. O. Box 98024
Baton Rouge, La 70898-9024

Remember, the Plan Participant must ALWAYS refer to his contract number in all correspondence and recheck it against the contract number on his ID card to be sure it is correct.

* HMO Louisiana, Inc. has Local Service Offices located in Baton Rouge, New Orleans and Shreveport.

ARTICLE XXIII. RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator

Comprehensive Medical Benefit Plan for EBR is the Benefit Plan of East Baton Rouge Parish School System**,** the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by East Baton Rouge Parish School System to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, East Baton Rouge Parish School System shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Benefit Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Benefit Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Benefit Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section.

Service of legal process may be made upon the Plan Administrator.

B. Duties of the Plan Administrator

1. to administer the Plan in accordance with its terms;

2. to interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;

3. to decide disputes that may arise relative to a Plan Participant's rights;

4. to prescribe procedures for filing a claim for Benefits and to review claim denials;

5. to keep and maintain the Plan documents and all other records pertaining to the Plan;

6. to appoint a Claims Administrator to pay Claims;

7. to establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609; and

8. to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

C. Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

D. Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

1. Fiduciary Duties

   A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to Plan Participants and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

   a. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

   b. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

   c. in accordance with the Plan documents.

2. The Named Fiduciary

   A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

   a. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

   b. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

E. The Claims Administrator is not a Fiduciary

A Claims Administrator is NOT a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

ARTICLE XXIV.	**GENERAL PLAN INFORMATION**
NAME OF PLAN:	East Baton Rouge Parish School System
NAME AND ADDRESS OF EMPLOYER/PLAN SPONSOR:	East Baton Rouge Parish School System 1050 South Foster Drive, Baton Rouge, LA 70806
EMPLOYER IDENTIFICATION NUMBER (EIN):	72-6000353
PLAN NUMBER (PN):	501
TYPE OF PLAN:	Group Major Medical Benefit Plan
FUNDING MEDIUM AND TYPE OF ADMINISTRATION:	The Plan is a self-funded Group Health Plan. Benefits are administered, on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administration Services Agreement and the terms and conditions of the Benefit Plan.
PLAN ADMINISTRATOR:	East Baton Rouge Parish School System 1050 South Foster Drive, Baton Rouge, LA 70806 Telephone Number: 225-922-5400 Fax Number: 225-922-5622
AGENT FOR SERVICE OF LEGAL PROCESS:	East Baton Rouge Parish School System Attention: Legal Division 1050 South Foster Drive, Baton Rouge, LA 70806
CLAIMS ADMINISTRATOR:	HMO Louisiana, Inc. 5525 Reitz Avenue Baton Rouge, LA 70809 (225) 295-3307 HMO Louisiana, Inc. has been hired to process claims under the Plan. BCBSLA does not serve as an insurer, but merely as a claims processor. Claims for Benefits are sent to HMO Louisiana, Inc. HMO Louisiana, Inc. process and pays claims, then requests reimbursement from Plan. East Baton Rouge Parish School System is ultimately responsible for providing plan Benefits, and not HMO Louisiana, Inc.
PLAN YEAR ENDS:	December 31st
PLAN DETAILS:	The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any benefits are described in the Benefit Plan.
FUTURE OF THE PLAN:	Although the Plan Sponsor expects and intends to continue the Benefit Plan indefinitely, the Group reserves the right to modify, amend, suspend, or terminate the Benefit Plan at any time.

ARTICLE XXV. HIPAA PRIVACY OF PROTECTED HEALTH INFORMATION

Introduction: This group health plan document satisfies the requirements of 45 C.F.R. § 164.504(f) of the Privacy Rules for an employer or other plan sponsor to obtain plan participants' protected health information to provide plan administration functions for its group health plan. This plan document sets out the requisite "satisfactory assurance" regarding the plan sponsor's representations on the uses and disclosures of plan participants' protected health information for plan administration functions.

A. Purpose of Disclosure to Group

1. The Plan and any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Group only to permit the Group to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Group of Plan participants' Protected Health Information (PHI) will be subject to and consistent with the provisions of paragraphs B. and D. of this section.

2. Neither the Plan nor any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Group unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan participants.

3. Neither the Plan nor business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Group for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Group.

B. Restrictions on Group's Use and Disclosure of Protected Health Information

1. The Group will neither use nor further disclose Plan participants' Protected Health Information, except as permitted or required by the Plan Document, as amended, or as required by law.

2. The Group will ensure that any agent, including any subcontractor, to which it provides Plan participants' Protected Health Information, agrees to the restrictions and conditions of the Plan Document, including this section, with respect to Plan participants' Protected Health Information.

3. The Group will not use or disclose Plan participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Group.

4. The Group will report to the Plan any use or disclosure of Plan participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

5. The Group will make Protected Health Information available to the Plan or to the Plan participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

6. The Group will make Plan participants' Protected Health Information available for amendment, and will, on notice, amend Plan participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

7. The Group will track disclosures it may make of Plan participants' Protected Health Information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

8. The Group will make its internal practices, books, and records relating to its use and disclosure of Plan participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E "Privacy of Individually Identifiable Health Information."

9. The Group will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan participant Protected Health Information, in whatever form or medium, received from the Plan or any business associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any participant who is the subject of the Protected Health Information, when the Plan participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan participant Protected Health Information, the Group will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan participant Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

C. Adequate Separation Between the Group and the Plan

1. The employees, classes of employees or other workforce members identified in section D., who are under the control of the Group, may be given access to Plan Participants' Protected Health Information received from the Plan or business associate servicing the Plan.

2. The employees, classes of employees or other workforce members identified in section D. will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that the Group provides for the Plan.

3. The employees, classes of employees or other workforce members identified in section D. will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Group, for any use or disclosure of Plan participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section. Group will promptly report such breach, violation or noncompliance to the Plan, as required by section B.(4.) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

D. Authorized Employees

The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer as follows:

Chief Business Operations Officer, General Counsel, Director of Finance, Chief Accountant, Budget Analyst, Supervisor of Payroll/Benefits, Supervisor of Accounting, Grants Fiscal Officer, Staff Accountant, Grants Specialist IV, Finance Specialist IV, Budget Specialist, Administrative Secretary, Finance Specialist III, Finance Specialist II, Payroll/Benefits Specialist II, Finance Specialist I, Benefits Specialist I, Accounting Specialist I and Insurance Consultant/Broker.

This list includes every employee or class of employees or other workforce members under the control of the Group who may receive Plan participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.