PremierBlue

Comprehensive Group Benefits Plan

For The

City of Baton Rouge
Parish of East Baton Rouge

Provided by

BlueCross BlueShield of Louisiana

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

5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802

www.bcbsla.com

Mike Reitz

President and Chief Executive Officer

Louisiana Health Service & Indemnity Company

BlueCross BlueShield of Louisiana

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SCHEDULE OF BENEFITS
PREMIER BLUE BENEFIT PLAN

GROUP NAME	**GROUP NUMBER**
City of Baton Rouge/Parish of East Baton Rouge	75897
GROUP'S ORIGINAL BENEFIT PLAN DATE	**GROUP'S ANNIVERSARY DATE**
January 1, 2012	January 1st
GROUP'S AMENDED BENEFIT PLAN DATE	
n/a	

SCHEDULE OF BENEFITS

Benefit Period	Calendar Year for all Providers

DEDUCTIBLE/OUT-OF-POCKET AMOUNT

	NETWORK PREFERRED CARE	NON-NETWORK ALL OTHER PROVIDERS
Benefit Period Deductible		
Individual	$500	$1,000
Family Aggregate	$1,500	$3,000
Out-Of-Pocket Amount	$2,500	$6,000
Family Out-Of-Pocket Amount	$5,000	$12,000

PRESCRIPTION DRUGS

Prescription Drug Deductible (Must be met prior to application of a Copayment)	$250 per Member each Benefit Period for Brand Prescriptions only; Generic – no Deductible.

	RETAIL	MAIL
Tier 1	$4	$8
Tier 2	$30	$60
Tier 3	$50	$100
Tier 4	$70	$140
Tier 5*	$60	$120

*** Includes only covered injectable drugs purchased from a pharmacy. Injectable insulin and injectable antihemophilic prescription drugs are included in another tier.**

Dispensing limitation per prescription or refill	Up to a 30 day supply	Up to a 90 day supply

Specialty Drugs may be limited to a thirty (30) day supply.

Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance.

Benefits are available for contraceptive drugs.

PREGNANCY CARE		
Benefits are available for Pregnancy Care. Ectopic pregnancies and miscarriages are not considered Pregnancy Care. Benefits are available for treatment received for these conditions under Hospital and Surgical Medical Benefits.		
COPAYMENTS AND COINSURANCE		
	NETWORK PREFERRED CARE	**NON-NETWORK ALL OTHER PROVIDERS**
	Copayments shown are the Member's responsibility Coinsurance shown as Company-Member responsibility	
Outpatient visits for the following services: Physician's office visits including Preventive and Wellness care office visits, for the following Physician/Allied Health Professional specialties: • General Practice • Family Practice Physician's Assistant • Pediatrics • Internal Medicine • Chiropractor • Physician's Assistant	$25 per visit	70% - 30%
Allied Health Professional office visits for the following specialties: • Rehabilitative Care	80%-20%	70% - 30%
Speech Therapy	80%-20%	70% - 30%
Employee Assistance Counseling	3 Visits (no copay/coin)	70% - 30%
Specialist office visits	$35 per visit	70% - 30%
Vision Care Exam, limited to 1 exam in a 24-month period.	$35 per visit	$35 per visit
Refractive Errors of the Eye including but not limited to Radial Keratotomy	50% - 50%	Not Covered
Urgent Care Center	$40 per visit	70% - 30%
Emergency Medical Services performed in the Emergency Department of a Hospital (Hospital Facility charge).	$150 per visit; waived if admitted.	$150 per visit; waived if admitted.
Ambulance Services	$100 per day per Provider	70% - 30%
Air Ambulance Services	$200 per day per Provider	70% - 30%
Ambulatory Surgical Center and Outpatient Surgical Facility	$200 per surgical visit	70% - 30%
Physician Outpatient Surgical Services	$100 copayment per day	70% - 30%
Inpatient Hospital Admission, all Inpatient Hospital services included	$200 per day; 5 day maximum. $1,000 maximum.	70% - 30%
Physician's services for Pregnancy Care Services received for Pregnancy Care from other Providers such as a Hospital, Emergency Room, Urgent Care Center or Ambulatory Surgical Center are subject to the applicable Copayments or Coinsurance shown for each, if any.	$50 per pregnancy	70% - 30%
Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices	80% - 20%	70% - 30%

Services for: • Home Health Care • Hospice, limited to 185 days • Skilled Nursing Facility, limited to 100 days	100% - 0%		70% - 30%

MENTAL HEALTH AND SUBSTANCE ABUSE

Mental Health and Substance Abuse	NETWORK PREFERRED CARE	NON-NETWORK ALL OTHER PROVIDERS
Outpatient Mental Health and Substance Abuse Benefits (includes Outpatient facility, office visits and Outpatient therapies).	100%	70% - 30%
Inpatient Mental Health and Substance Abuse Benefits (includes Inpatient professional services).	100%	70% - 30%
Inpatient Hospital Copayments and/or Inpatient Coinsurance amounts for Mental Health and Substance Abuse	Payable same as medical benefits.	Payable same as medical benefits.
All other services are payable the same as medical benefits.		

ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

- Benefits are paid the same as for any other illness.
- Organ, tissue and bone marrow transplants and evaluation for a Member's suitability for organ, tissue bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered.
- Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

PRIVATE DUTY NURSING

Benefits for Private Duty Nursing are limited to a maximum amount of $5,000.00 each Benefit Period for each Member.

DIETICIAN VISITS

Benefits are limited to a maximum of $250.00 in Allowable Charges per Benefit Period for each Member.

AUTHORIZATION OF ADMISSIONS

All Elective, Non-Emergency and Emergency Inpatient Hospital Admissions require authorization from Blue Cross and Blue Shield of Louisiana. Refer to Authorization of Services and Supplies and if applicable, Pregnancy Care Benefits in this Benefit Plan for complete information.

Requests for authorization of Inpatient Admissions, for Concurrent Review of an Admission in progress, or Other Covered Services and Supplies must be made to Blue Cross and Blue Shield of Louisiana by calling: 1-800-523-6435.

AUTHORIZATION OF OUTPATIENT SERVICES,
INCLUDING OTHER COVERED SERVICES AND SUPPLIES:

The following Outpatient services and supplies require Authorization prior to the services being rendered or supplies being received.
Benefits are payable same as any other illness

- Applied Behavior Analysis
- Bone growth stimulator
- CT Scans
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice Care
- Hyperbarics
- Implantable Medical Devices over $2000.00 such as Implantable Defibrillator and Insulin Pump
- Intensive Outpatient Programs
- M.R.I./M.R.A.
- Non-Emergency Air Ambulance
- Nuclear Cardiology
- Partial Hospitalization Programs
- PET Scans/SPECT Scans
- Private Duty Nursing
- Prosthetic Appliances
- Residential Treatment Centers
- Sleep Studies
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Vacuum Assisted Wound Closure Therapy

If Authorization is not requested prior to a listed service being rendered or a listed supply being received, We will have the right to determine if the service or supply was Medically Necessary. If the service or supply was Medically Necessary, Benefits will be provided based on the participating status of the Provider of the service or supply. If a contracted Provider in Louisiana's Preferred Care (or PCare) Network fails to obtain a required Authorization, we will reduce his Benefit payment thirty percent (30%) of the Allowable Charge. This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Preferred Care Provider is responsible for all charges not covered and for the penalty amount. The Member remains responsible for his Copayment, Deductible amount and applicable Coinsurance percentage. If a service or supply was not Medically Necessary, the service or supply is not covered.

Refer to the "Authorization of Services and Supplies, and if applicable, Pregnancy Care Benefits section of the Benefit Plan for complete information.

AUTHORIZATION FOR PRESCRIPTION DRUGS

The following categories of Prescription Drugs require prior authorization. The Member's Physician must call 1-800-376-7741 to obtain the authorization. Call the customer service number on the Member's I.D. card or check our website at www.bcbsla.com to determine what categories of Prescription Drugs require prior authorization.

Categories of Prescription Drugs that require prior Authorization.

Specialty Drugs Examples may include, but are not limited to:
- Growth hormones*
- Anti tumor necrosis factor drugs*
- Intravenous immune globulin*

- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*

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

Traditional drugs that are not considered to be Specialty Drugs, are typically self administered, and commonly dispensed by retail pharmacies. Examples may include but are not limited to:

- Provigil®, Nuvigil®, Symlin®, Byetta®, Victoza®

Controlled Dangerous Substances – Examples may include but are not limited to:
- Actiq®, OxyContin®

Therapeutic/Treatment Vaccines – Examples include, but are not limited to vaccines to treat the following conditions:
- Allergic Rhinitis
- Alzheimer's Disease
- Cancers
- Multiple Sclerosis

Substance Addiction, if covered on this policy

PRE-EXISTING CONDITION EXCLUSION PERIOD

The exclusion for a Pre-Existing Condition is applicable as stated in 'Limitations And Exclusions'. A Member may receive credit toward this exclusionary period for any time he served toward a Pre-Existing Condition Exclusion Period under his prior coverage. See the Benefit Plan for complete details.

BlueCross BlueShield of Louisiana

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CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE

NON-GRANDFATHERED PREMIER BLUE
HEALTH BENEFIT PLAN

NOTICE

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 (888) 224-2583 or (225) 293-2583 on the back of Your identification (ID) card.

Your share of the payment for health care services may be based on the agreement between 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.

Mike Reitz
President and Chief Executive Officer
Louisiana Health Service & Indemnity Company

Blue Cross and Blue Shield of Louisiana Incorporated as Louisiana Health Service & Indemnity Company

CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE
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ARTICLE I. UNDERSTANDING THE BASICS

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

As of the Benefit Plan Date shown in the Plan's Schedule of Benefits, the Plan agrees to provide the Benefits specified herein for Plan Participants of the Plan and their enrolled Dependents. This Benefit Plan replaces any others previously issued to participants on the Benefit Plan Date or the amended Benefit Plan Date. This Plan describes Your Benefits, as well as Your rights and responsibilities under the Plan. You are encouraged to read this Benefit Plan carefully.

You should call the Plan'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. "The Claims Administrator," "Us" and "Our" means **Blue Cross and Blue Shield of Louisiana**. "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.

FACTS ABOUT THIS PREMIER BLUE BENEFIT PLAN

The Plan is a comprehensive Group health plan with Benefits similar to a point-of-service plan. It has Copayment, Deductible and Coinsurance Benefits. A Plan Participant may choose to receive Benefits from a PPO Provider (Network Provider) or a Provider outside the PPO Network (a Non-Network Provider). A Plan Participant must meet a Deductible before a Copayment applies when seeking care from a Network Provider, and must meet a Deductible before Coinsurance applies for services received from a Non-Network Provider. The Plan Participant's choice of a Provider usually determines whether a Copayment or Deductible and Coinsurance apply.

CLAIMS ADMINISTRATOR'S PREFERRED 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.

The Preferred Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with the Claims Administrator to participate in the Blue Cross and Blue Shield of Louisiana Preferred Provider Network and render services to the Plan Participants. These Providers are called "Preferred network providers." Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's dental network.

To obtain the highest level of Benefits available, the Plan Participant should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Network 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 Plan'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 Out-of-Network when rendering services from another location. The Plan Participant should make sure to check his 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 certain 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 the Claims Administrator to perform (such as certain high-tech diagnostic or radiology procedures), Claims for those services will be adjudicated at the Non-Network Benefit level. 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.

RECEIVING CARE OUTSIDE THE PREFERRED NETWORK

The Preferred Network is an extensive network and should meet the needs of most Plan Participants. However, Plan Participants choose which Providers will render their care, and Plan Participants may obtain care from Providers who are not in the Preferred Network.

The Plan pays a lower level of Benefits when a Plan Participant uses a Provider outside the Preferred Network. Benefits may be based on a lower Allowable Charge, and/or a penalty may apply. Care obtained outside the Claims Administrator's network means the Plan Participant has higher Out-of-Pocket costs and pays a higher Copayment, Deductible, and/or Coinsurance than if he had stayed In-Network. THESE ADDITIONAL COSTS MAY BE SIGNIFICANT. In addition, the Plan only pays a portion of those charges and it is the Plan Participant's responsibility to pay the remainder. The amount the Plan Participant is required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum.

It is recommended that the Plan Participant ask Non-Network Providers to explain their billed charges, before care is received outside the Network. You should review the sample illustration below prior to obtaining care outside the Network.

AUTHORIZATIONS

Some services and supplies require Authorization from the Claims Administrator before services are obtained. Your Schedule of Benefits lists the services, supplies, and prescription drugs that require this advance Authorization.

No payment will be made for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless the Plan Authorizes these services and the services are rendered by a Blue Distinction Center for Transplants or a transplant facility in the Blue Cross and Blue Shield Preferred Provider Network, unless otherwise approved by the Plan in writing. To locate an approved transplant facility, Plan Participants should contact the Plan's customer service department at the number listed on their ID card.

HOW THE PLAN DETERMINES WHAT IS PAID FOR COVERED SERVICES

When a Plan Participant Uses Preferred network providers

Preferred network providers are Providers who have signed contracts with the Claims Administrator or another Blue Cross and Blue Shield plan to participate in the Preferred Network. These Providers have agreed to accept the lesser of billed charges or an amount negotiated as payment in full for Covered Services provided to Plan Participants. This amount is the Preferred network provider's Allowable Charge. If the Plan Participant uses a Preferred network provider, this Allowable Charge is used to determine the Plan's payment for the Plan Participant's Medically Necessary Covered Services and the amount that the Plan Participant must pay for his Covered Services.

When a Plan Participant Uses Participating Providers

Participating Providers are Providers who have signed contracts with the Claims Administrator or another Blue Cross and Blue Shield plan for other than the Preferred Network. These Providers have agreed to accept the lesser of billed charges or the negotiated amount as payment in full for Covered Services provided to the Plan Participant. This amount is the Participating Provider's Allowable Charge. When a Plan Participant uses a Participating Provider, this Allowable Charge is used to determine the amount the Plan pays for Medically Necessary Covered Services and the amount the Plan Participant pays.

When a Plan Participant Uses Non-Participating Providers

Non-Participating Providers are Providers who have not signed any contract with the Claims Administrator or any other Blue Cross and Blue Shield plan to participate in any Blue Cross and Blue Shield Network. These Providers are not in the Claims Administrator's Networks. The Claims Administrator has no fee arrangements with them. The Claims Administrator establishes an Allowable Charge for Covered Services provided by Non-Participating Providers. The lesser of the Provider's actual billed charge or the established Allowable Charge is used to determine what to pay for a Plan Participant's Covered Services when he 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 Preferred Provider.

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, Preferred 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 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.

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 a PPO plan with a $500 Deductible Amount. The Plan Participant has 80/20 Coinsurance when the he receives Covered Services from Hospitals in the Preferred Network and 70/30 Coinsurance when he receives Covered Services from Hospitals that are not in the Preferred Network. Assume the Plan Participant goes to the Hospital, has previously met his Deductible, and has obtained the necessary Authorizations prior to receiving a non-emergency service. The Provider's billed charge for the Covered Services is $12,000. The Company negotiated an Allowable Charge of $2,500 with its Preferred Network Hospitals 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 Hospital.

The Plan Participant receives Covered Services from:	Preferred network 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:	$2,000 $2,500 Allowable Charge x 80% Coinsurance = $2,000	$2,100 $3,000 Allowable Charge x 70% Coinsurance = $2,100	$1,750 $2,500 Allowable Charge x 70% Coinsurance = $1,750
Plan Participant pays:	$500 20% Coinsurance x $2500 Allowable Charge = $500	$900 30% Coinsurance x $3,000 Allowable Charge = $900	$750 $2,500 x 30% = $750
Is Plan Participant billed up to the Provider's billed charge?	NO	NO	YES - $9,500, for a total of:
Total Plan Participant Pays:	$500	$900	$10,250

WHEN A PLAN PARTICIPANT PURCHASES COVERED PRESCRIPTION DRUGS

Some pharmacies have contracted with the Claims Administrator or with its Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base the Plan's payment for a Plan Participant's covered Prescription Drugs and the amount that the Plan Participant must pay for his covered Prescription Drugs.

When a Plan Participant purchases covered Prescription Drugs from a pharmacy that has not contracted with the Claims Administrator or with its Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense, the Allowable Charge is the negotiated amount that most Participating Pharmacies have agreed to accept as payment for drugs dispensed.

WHEN A PLAN PARTICIPANT RECEIVES MENTAL HEALTH OR SUBSTANCE ABUSE BENEFITS

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

ASSIGNMENT

A Plan Participant's rights and Benefits 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 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, 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 Plan or the Claims Administrator liable to any third party to whom a Plan Participant may be liable to for the cost of medical care, treatment, or services.

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

PLAN PARTICIPANT INCENTIVES

Sometimes the Plan 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 Plan 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 memberships, diet and weight control programs, vision and hearing care and more.

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. 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.

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 Benefit Plan, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, Physician's assistant, registered nurse first assistant, advanced practice registered nurse, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by Us 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 establish by the Claims Administrator or negotiated as the maximum amount allowed for all Provider services covered under the terms of this Benefit 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 means of a licensed, specially designed and equipped vehicle used only for transporting the sick and injured.

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 the Plan Participant or his authorized representative to change a previous decision made by the Claims Administrator. Examples of issues that qualify as Appeals include denied Authorizations, Claims based on adverse determinations of Medical Necessity, or Benefit determinations.

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 a behavior analyst by the Behavior Analyst Certification Board or shall provide, upon request, documented evidence satisfactory to the Plan, of equivalent education, professional training, and supervised experience in ABA.

Authorization (Authorized) - A determination by the 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 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, drugs, devices, items or supplies provided under this Plan. Benefits provided by the Plan 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 - The program established by the Group to provide 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.

Brand-Name Drug - A Prescription Drug that is a patented drug marketed by the original drug manufacturer following its Food and Drug Administration ("FDA") approval, or that the Plan identifies as a Brand-Name product. The Plan classifies a prescription drug as a Brand-Name Drug based on a nationally recognized pricing source, therefore all products identified as a "Brand-Name" by the manufacturer or pharmacy may not be classified as a Brand-Name Drug by the Plan.

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's option administered by medical professionals, which focuses on unusually complex, difficult or catastrophic illnesses. Working with the Plan Participant's Physician(s) and subject to the Plan Participant's consent 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.

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 the 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 Blue Cross and Blue Shield of Louisiana.

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.

Coinsurance - The sharing of Allowable charges for Covered Services. The sharing is expressed as a pair of percentages, a Company percentage that the Plan pays, and a percentage that 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 - Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service & Indemnity Company).

Complaint - An oral expression of dissatisfaction with the Claims Administrator 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, the Plan 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 palate.

Consultation - Another Physician's opinion or advice as to the evaluation of a Plan Participant, 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 amount of charges for a Covered Service, which a Plan Participant must pay for specified Covered Services. The Copayment may be collected directly from a Plan Participant by a Network Provider each time a specified Covered Service is rendered.

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 for HIPAA Portability - 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.

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

Deductible Amounts

A. Benefit Period 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 Benefits are provided.

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

B. Family Deductible Amount, if shown in the Schedule of Benefits, is the amount shown in the Schedule of Benefits for each category of Benefits to which a Deductible applies. Once a family has met its Family Deductible, this Plan starts paying Benefits for all members of the family, regardless of whether each individual has met his individual amount. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan.

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 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 - A person, other than the Plan Participant, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

Diagnostic Service - Radiology, laboratory, and pathology services and other tests or procedures recognized by the Plan 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 is 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 or Late Enrollee, any period before such Special or Late 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 – Those medical services necessary to screen, evaluate and stabilize an Emergency Medical Condition.

Employee - A person who is an active, regular Employee of the Employer, who works the required number of hours for coverage, as designated by Employer.

Employer – City of Baton Rouge/Parish of East Baton Rouge

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

Expedited Appeal - Any request concerning an Admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who is requesting Emergency services or 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, not to authorize continued services for Plan Participants currently in the Emergency room, under observation, or receiving Inpatient care.

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

Grievance - A written expression of dissatisfaction with the Claims Administrator or with Provider services.

Group – CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE or other legal entity of CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE who is the Plan Administrator and Sponsor of this Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

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 and approved by the Claims Administrator. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse (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 approved by the Plan.

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 Us, which conducts external reviews of final adverse determinations. The decision of the IRO is binding on both the insured and Us.

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.

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 the Claims Administrator makes 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.

Late Enrollee - An individual who enrolls in this Plan other than during the initial period in which he is eligible to enroll in this Plan or other than during any Special Enrollment Period.

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 as 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 - 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 L.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 Plan. 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.

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

Network Benefits - Benefits for care received from a Network (PPO) Provider.

Network Provider - A Provider that has signed an agreement with Us or another Blue Cross and Blue Shield plan to participate as a member of the Preferred Care Provider Network or a PPO Network.

Newly-Born Infant - An infant from the time of birth until age one (1) month or until such time as 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.

Non-Network Provider - A Provider who is not a member of Our Preferred Care Network or another Blue Cross Blue Shield plan PPO Network.

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 impairment and/or improve functional performance. These can include the design, fabrication or application of Orthotic 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 Plan, during which an Employee and their eligible Dependents may enroll for Benefits under this Plan.

Open Enrollment Period - Unless otherwise specified in the Schedule of Benefits, the Open Enrollment Period means the thirty (30) day period prior to the beginning of each Plan Year.

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 – City of Baton Rouge/Parish of East Baton Rouge's medical Benefits plan for certain Employees of City of Baton Rouge/Parish of East Baton Rouge 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 – Any Employee, Retiree or Dependent who is covered under this Plan.

Plan Sponsor – City of Baton Rouge/Parish of East Baton Rouge**,** 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.

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.

Prescription Drug Copayment - The amount a Plan Participant must pay for each prescription at a participating pharmacy at the time a prescription is filled. A different Copayment may be required for the different drug tiers purchased at a retail pharmacy or through the mail.

Prescription Drug Deductible Amount - The amount, if shown in the Schedule of Benefits, which must be met by a Plan Participant or a family within a Benefit Period prior to any applicable Prescription Drug Copayment or Coinsurance percentage.

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.

Private Duty Nursing Services - Services of an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) 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 R.N. or L.P.N. in shifts of at least eight (8) continuous hours.

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.

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 the 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. Preferred Provider – A Provider who has entered into a contract with the Claims Administrator or another Blue Cross and Blue Shield plan to participate in a PPO Network.

B. Participating Provider – A Provider that has a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan for other than a Preferred Network Provider.

C. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan.

Rehabilitative Care - The coordinated use of medical, social, educational or vocational services, beyond the acute care stage of disease or injury, for the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

Residential Treatment Center – 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 Employee who has terminated employment and is receiving a benefit from the City-Parish Retirement System, the Municipal Police Employees Retirement System, or one of the retirement systems for the agencies participating in the City-Parish Health Insurance Plan. A Vested Retiree is also considered a retiree for the period from termination of employment until a retirement benefit is received.

Significant Break in Coverage - A period of sixty-three (63) or more consecutive days during all of which an individual does not have any Creditable Coverage. Periods without coverage during an Eligibility Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in coverage has occurred.

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 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 is approved by the Claims Administrator 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 who is entitled to and who requests special enrollment (as described in this 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.

Specialty Drugs - Biotechnology drugs or other drug products that may require special ordering, handling, and/or customer service, examples of which include, but are not limited to protein drugs, monoclonal antibodies, interferons, antisense drugs, epidermal growth factor inhibitors, and gene therapies.

Speech/Language Pathology Therapy - The treatment of a speech/language impairment or a swallowing impairment to improve or restore speech language deficits or swallowing deficits.

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 as defined and approved by the Plan.

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.

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

Therapeutic/Treatment Vaccine – A vaccine intended to treat infection or disease by stimulating the immune system to provide protection against the infection or disease.

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 a Plan Participant's Physician's normal business hours.

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.

ARTICLE III. SCHEDULE OF ELIGIBILITY

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

A. Eligibility

The Eligibility Date is the first billing date after an Employee becomes eligible and enrolls in the Plan.

The person is eligible for coverage under this Plan if he is an Employee, as defined in the City of Baton Rouge and Parish of East Baton Rouge Health Care Plan. The Employee also must work at least thirty (30) hours per week and be enrolled in the City-Parish health coverage.

The Employee is also eligible for coverage if:

- The Employee who is retired from active employment and is considered a Retiree by the City-Parish; and
- The Employee who was covered under the City-Parish health plan continuously for a period of one year prior to retirement.
- The Surviving Dependent receiving a retirement benefit; and
- Once the retired Employee or dependent of a retired Employee turns sixty-five (65) years, he must enroll in Medicare Part B if he is eligible for free Part A. If he is not eligible for free Part A, then he must furnish a statement from Social Security stating his ineligibility. If he fails to do either, he shall lose eligibility for himself and all his dependents to participate in this plan.

Eligible Dependents

Dependents eligible for coverage under this plan are the Employee's lawful spouse and/or the Employee's Dependent children under age twenty-six (26). A child must meet the following definition in order to be eligible:

- The Employee's natural child;
- The Employee's legally adopted child or child who has been placed in the Employee home pursuant to an adoption agreement;
- The Employee's child in the legal custody of and residing with the Employee, who is incapable of self-sustaining employment by reason of being mentally or physically disabled prior to attaining age twenty-six (26). The Employee must furnish the Plan with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's twenty-sixth (26th) birthday. The Plan may require subsequent proof once a year after the initial two-year period following the child's twenty-sixth (26th) birthday.
- A child for whom the Employee is the legal guardian; or
- A stepchild who lives with the Employee in a normal parent/child relationship.

No Dependent will be covered under this plan until the required documents establishing dependency are received. No one may be covered as a Dependent of more than one employee.

B. Enrollment

To join this Plan, the Employee must complete an enrollment form and furnish it to the Payroll/Benefits Division of the City – Parish Human Resources Department within thirty (30) days on becoming eligible. If the Employee does not enroll within the thirty (30) day limit and does not meet the qualifications of a Special Enrollee as provided below, the Employee may not enroll in the Plan until the next Open Enrollment period.

If the person is a newly hired Employee, coverage begins on the first of the month following the day the person is both eligible to participate in and enrolled in the Plan.

If the Employee enrolls during the initial Open Enrollment period, coverage under this Plan will begin January 1 of the following year, which will be the first day of the Plan Year for which the employee is enrolled. If the Employee fails to return the enrollment form during the Open Enrollment period, We will deem the Employee's existing election and enrollment as unchanged and the Employee's existing election and enrollment will continue during the next Plan Year, except as provided under "Special Enrollment" below.
No one may be enrolled as both an Employee or Retiree and a Dependent.

Provided that the Employee has enrolled his eligible Dependents, their coverage will become effective on the later of:

- the day the Employee's coverage begins, or
- the first of the month following the day the Employee enrolls them in the plan.

Any Dependent child born or acquired while the Employee is enrolled for Dependent coverage, will be covered from the child's date of birth or the date of placement in the Employee's home for adoption, provided the Employee enrolls the child within thirty (30) days of the child's birth or placement for adoption.

It is the Employee's responsibility to notify the Payroll/Benefits Division of the City-Parish Human Resources Department promptly when the Employee needs to add new Dependents or when a covered individual is no longer an eligible Dependent. New Dependents are eligible to join this Plan immediately if they are enrolled within thirty (30) days of the qualifying event (marriage, birth, adoption, or placement for adoption). If the Employee does not enroll any eligible Dependents within thirty (30) days of the qualifying event, the Employee may not enroll them until the next Open Enrollment period.

Special Enrollment

If the Employee declined coverage under this Plan because the Employee had alternative health coverage at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently lost coverage under the other health plan, and the Employee makes application for coverage hereunder within thirty (30) days of the Employee's loss of coverage, the Employee shall be a Special Enrollee provided the Employee:

- was under a COBRA continuation provision and the coverage under the provision was exhausted; or
- was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.
- Individuals who lose other coverage due to nonpayment of premium or for cause (such as filing fraudulent claims) shall not be a Special Enrollee hereunder.
- is an eligible person or eligible Dependent who seeks to enroll in the Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption and enrolls within thirty (30) days of the acquisition of the new Dependent.

Coverage for a Special Enrollee (other than a newborn or newly adopted child) shall begin as of the first day of the calendar month following enrollment request. Coverage for a newly adopted or newborn Special Enrollee shall begin as of the date of the adoption, birth or placement for adoption.

Special Enrollment Due to Loss of Coverage under the Children's Health Insurance Program or a Medicaid Program

a. This Plan provides for a Special Enrollment Period for an Employee or family Dependent(s) if either (1) are covered under Medicaid or State Children's Health Insurance Program ("CHIP"), and lose that coverage because of loss of eligibility; or (2) they become eligible for premium assistance under the CHIP program. To qualify, Employee must request coverage in this Plan no later than sixty (60) days after either the date of coverage termination under Medicaid or CHIP or the date Employee or Dependent is determined to be eligible for such premium assistance. Request for special enrollment under this section must be received by City-Parish Human Resources Payroll and Benefits Division within the sixty (60) day period following loss of coverage or the date Employee or Dependent is determined to be eligible for premium assistance. When special enrollment under this section is made timely and received by the Plan timely, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP, or the date Employee or Dependent is eligible for premium assistance.

b. Employee may disenroll a child Dependent from this coverage and enroll the child in CHIP coverage effective the first day of any month for which the child is eligible for such CHIP coverage. Employee must promptly notify the Plan in writing of the child's disenrollment to avoid continued coverage under this Plan.

Special Enrollment Due to Acquiring a Dependent

In the case of a birth, adoption, or placement for adoption, a current Employee may enroll himself, his spouse and/or the newborn/adopted child. The enrollment must be requested by signing an enrollment form within thirty (30) days of the birth, adoption, or placement for adoption. If the enrollment form is received by the Plan within thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth, adoption, or placement for adoption.

ARTICLE IV. BENEFITS PROVIDED

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

1. The Premier Blue Benefit Plan includes the following categories of Benefits:

   a. Network Benefits: Benefits for Covered Services received from a Network Provider (Providers contracted in the Preferred Care Network or another Blue Plan's PPO Network).

   b. Non-Network Benefits: Benefits for Covered Services received from Non-Network Providers (Providers not contracted in the Preferred Care Network or another Blue Plan's PPO Network).

   c. Under certain circumstances, if Company pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, Company may collect such amounts directly from You. You agree that Company has the right to collect such amounts from You.

   NOTE: No Benefits are available for Organ, Tissue and Bone Marrow Transplants or evaluations if Authorization is not received prior to services being rendered.

2. Network Benefits

   a. If a Copayment, Deductible, or Coinsurance is shown for a Covered Service, the Plan Participant must pay any applicable Copayment each time the Covered Service is rendered, subject to any limitations or maximum Benefits shown in the Schedule of Benefits.

   b. If a Coinsurance is shown for a Covered Service, the Plan Participant must pay any applicable Benefit Period Deductible Amount and that Coinsurance percentage, subject to any limitations or maximum Benefits shown in the Schedule of Benefits. The Plan will provide Benefits for Covered Services based on the Allowable Charges for those services for which a Coinsurance percentage is applicable.

3. Non-Network

    a. 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 pay Our Allowable Charges toward the Covered Services rendered to a Plan Participant during a Benefit Period. The Plan's actual payment to a Provider or payment to the Plan Participant satisfies the Plan's obligation to provide Benefits under this Benefit Plan

B. Out-of-Pocket Amounts may be different for Network and Non-Network Benefits

1. The following accrue toward the Out-of-Pocket Amount, as shown in the Schedule of Benefits. After the Plan Participant has met the applicable Out-of-Pocket Amount, the Plan will pay one hundred percent (100%) of the Allowable Charge for the following Covered Services.

    a. Coinsurance;

    b. Hospital Inpatient Copayments; and

    c. Ambulatory Surgical Facility and Outpatient Surgical Facility Copayments.

2. The following do not apply toward satisfying the Out-of-Pocket Amount:

    a. Deductible Amounts;

    b. Copayments that the Plan Participant pays other than Inpatient Hospital Copayment, Ambulatory Surgical Facility and Outpatient Surgical Facility Copayments;

    c. any charges in excess of the Allowable Charge;

    d. any penalties the Plan Participant must pay;

    e. charges for non-Covered Services; and

    f. any amount paid by the Plan Participant other than those.

C. Deductible Amount

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 Us. 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. If the Plan Participant overpays his Deductible Amount, the Plan Participant is entitled to receive a refund from the Provider in which the overpayment was made.

D. Accumulator Transfers

Plan Participants' needs sometimes require that they transfer from one policy or plan to another. Types of transfers include, but are not limited to moving from one employer's plan to another, from a group policy or plan to an individual policy, an individual policy to a group policy or plan, or a policy with one insurance company to a policy with another insurance company. The type of transfer being made determines whether the Plan Participant's accumulators are carried from the old policy to the new policy. Accumulators include, but are not limited to, Deductibles, Out-of-Pocket Amounts, and Benefit Period Maximums.

ARTICLE V. HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-Emergency, Emergency, Pregnancy Care, Mental Disorders and substance abuse Admissions) must be Authorized as outlined in Authorization of Services. In addition, at regular intervals during the Inpatient stay, the Plan 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. 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.

The following services furnished to a Plan Participant by a Hospital are covered:

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.

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, for the maximum number of days per Benefit Period shown in the Schedule of Benefits.

4. In a Residential Treatment Center for Plan Participants with Mental Health and Substance Abuse Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

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

2. Drugs and medicines including take-home Prescription Drugs.

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

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

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

6. Diagnostic Services rendered by a Hospital employee.

7. Physical Therapy provided by a Hospital employee.

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

C. Emergency Room Benefits)

The Plan Participant may have to pay applicable Copayment, Deductible and/or Coinsurance Amounts as shown in the Schedule of Benefits, for each visit to an In-Network Emergency room for treatment. The Emergency room Copayment is waived if the In-Network visit results in an Inpatient Admission. Plan Participants obtaining care at a Non-Network Emergency room must pay any applicable Deductible Amount and Coinsurance percentage, subject to any limitations or maximum Benefits shown in the Schedule of Benefits.

D. Pre-Admission Testing Benefits

Benefits will be provided for the Outpatient Facility charge and associated professional fees for Diagnostic Services rendered within seventy-two (72) hours of a scheduled procedure performed at an Inpatient or Outpatient Facility.

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 to determine which services require Authorization. A Plan Participant must pay any applicable Copayments, Deductible Amounts, 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.

   c. Incidental Procedure

      (1) An incidental procedure is one carried out at the same time as a more complex primary procedure and which requires little additional Physician resources and/or is clinically integral to the performance of the primary procedure.

      (2) The Allowable Charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

   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 Plan will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as determined by the Claims Administrator.

   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 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

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

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. Services of an Ambulatory Surgical Center

3. Consultation (as defined in this Benefit Plan)

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

Existing drugs are covered subject to the Limitations and Exclusions portion of this Benefit Plan, and may be subject to Deductible and Coinsurance, Copayment tier placement, prior Authorization requirements, Quantity Per Dispensing limits, Step Therapy requirements and specialty pharmacy program requirements. New drugs are generally subject to the same provisions as existing drugs and are typically covered at the highest Copayment tier.

A. Coverage is available for Prescription Drugs if shown as covered on the Schedule of Benefits. The Prescription Drugs must be dispensed on or after the Plan Participant's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that the Plan determines and only those Prescription Drugs that the Plan determines are Medically Necessary will be covered. Certain Prescription Drugs may be subject to Step Therapy or require prior Authorization as shown on the Schedule of Benefits.

B. Prescription Drugs dispensed at retail or through the mail are subject to the Prescription Drug Copayment or Coinsurance Amount and any applicable Prescription Drug Deductible Amount shown on the Schedule of Benefits. The Plan Participant may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Plan Participant may be required to pay a different Copayment or Coinsurance depending on whether the Plan Participant's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.

C. If a Prescription Drug Deductible Amount is applicable, this amount must be satisfied prior to any applicable Prescription Drug Copayment or Coinsurance. The Prescription Drug Deductible Amount is separate from the Benefit Period Deductible Amount and do not accrue to the satisfaction of the Out-of-Pocket Amount.

D. Prescription Drug Copayments and Coinsurance are based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on the Claims Administrator's evaluation of a particular medication's clinical efficiency, safety, cost, and pharmacoeconomic factors.

   1. Tier 1 – A Prescription Drug that is a Generic or a low cost Brand-Name Drug.

   2. Tier 2 – A Prescription Drug that is a Brand-Name Drug.

   3. Tier 3 – A Prescription Drug that is a Brand-Name Drug or a Generic Drug that may have a therapeutic alternative as a Tier 1 or Tier 2 drug. Covered compounded drugs are included in this Tier.

   4. Tier 4 – A Prescription Drug that is a Multi-Source Brand Drug.

   5. Tier 5 – Injectable Prescription Drugs include those medications that are intended to be self-administered. However, insulin and injectable antihemophilic Prescription Drugs may be included in another drug tier.

E. Necessary insulin syringes and test strips are covered under the Prescription Drug Benefit.

F. The Plan Participant can view the Claims Administrator's Blue Selections Rx Plan Participant Guide on Our website at **www.bcblsa.com** or request a copy by mail by calling the Claims Administrator's pharmacy Benefit manager at the telephone number indicated on the Plan Participant's ID card.

G. Drug Utilization Management Program

   The Plan's Drug Utilization Management Program features a set of closely aligned programs that are designed to promote Plan Participant safety, appropriate and cost effective use of medications, and monitor health care

quality. Examples of these programs include:

1. Prior Authorization – As part of the Plan's Drug Utilization Management program, Plan Participants and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on the Claims Administrator's website at **www.bcbsla.com** or by calling the customer-service telephone number on the Plan Participant's ID card. If the Prescription Drug requires prior Authorization, the Plan Participant's Physician must call the medical Authorization telephone number on the Plan Participant's ID card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.

2. Safety checks – Before the Plan Participant's prescription is filled, the Claims Administrator's pharmacy Benefit manager or the Claims Administrator performs quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g. refill prior to seventy-five (75%) day supply used).

3. Quantity Per Dispensing Limits/Allowances – Prescription Drugs selected by the Claims Administrator are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity Per Dispensing Limits/Allowances are based on the following: (a) the manufacturer's recommended dosage and duration of therapy; (b) common usage for episodic or intermittent treatment; (c) FDA-approved recommendations and/or clinical studies; or (d) as determined by the Plan.

4. Step Therapy– In some cases, the Plan may require the Plan Participant to first try one Prescription Drug to treat a medical condition before the Plan will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Plan Participant's medical condition, the Plan may require the Plan Participant's Physician to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Plan will cover a prescription written for Drug B. However, if Your physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B Brand-Name drug included in the Step Therapy program without first trying a Step A generic alternative, You will be responsible for the full cost of the drug.

H. Some pharmacies have contracted with the Claims Administrator or with the Claims Administrator's pharmacy Benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." Benefits are based on the Allowable Charge as determined by the Claims Administrator. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base the Plan's payment for the Plan Participant's covered Prescription Drugs.

I. When a Plan Participant purchases covered Prescription Drugs from a pharmacy that has not contracted with the Claims Administrator or with the Claims Administrator's pharmacy Benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that it dispenses, the Allowable Charge is the negotiated amount that Participating Pharmacies have agreed to accept for drugs dispensed.

J. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Plan Participant should submit Claims on the Claims Administrator's Prescription Drug claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Plan Participant should contact the Claims Administrator or the Claims Administrator's Our pharmacy Benefit manager at the telephone number on his ID card.

K. As part of the Claims Administrator's administration of Prescription Drug Benefits, the Claims Administrator may disclose information about the Plan Participant's Prescription Drug utilization, including the names of the Plan Participant's prescribing Physicians, to any treating Physicians or dispensing pharmacies.

L. The Plan shall receive one hundred percent (100%) of savings realized by the Claims Administrator under their cost containment programs that are attributable to Claims under the Plan, through billing of actual payments for

Claims made under these programs.

M. The Specialty Pharmacy Program covers certain drugs commonly referred to as high-cost Specialty Drugs. The Claims Administrator contracts with Specialty Pharmacies to provide additional helpful services, such as courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the Specialty Drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis. Specialty Pharmacies specialize in dispensing and delivering drugs that require special handling. These Pharmacies comprise the "Specialty Pharmacy Network." The Plan Participant may contact the Claim Administrator's customer service department, or access **www.bcbsla.com/pharmacy**, to identify the drugs contained on the Specialty Drug list. Plan Participants may also access the website or contact the Claim Administrator's customer service department for assistance in locating the network specialty pharmacy that can be used to obtain medication.

ARTICLE VIII. PREVENTIVE or WELLNESS CARE

The following Preventive or Wellness Care services are available to a Plan Participant. The Deductible Amount does not apply to covered Preventive or Wellness Care, unless otherwise stated. If a Plan Participant receives Covered Services from a Network Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge. When Preventive or Wellness Care services are rendered by a Non-Network Provider, Benefits will be subject to the Coinsurance percentage as shown in the Schedule of Benefits.

WHAT A PLAN PARTICIPANT PAYS FOR PREVENTIVE OR WELLNESS CARE BENEFITS		
EXAMINATIONS AND TESTING:	**PREFERRED CARE NETWORK**	**ALL OTHER PROVIDERS**
Routine Wellness Physical Examination – Certain routine wellness diagnostic tests ordered by Your Physician are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Benefit include, but are not limited to tests such as 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. These higher tech services may be covered under standard contract Benefits when the tests are Medically Necessary.	No Cost	No Cost
Well Baby Care	No Cost	No Cost
Prostate Cancer Screening – One (1) digital rectal exam per Benefit Period, for Plan Participants fifty (50) years of age or older, and as recommended by a Physician if the Plan Participant is over forty (40) years of age.	No Cost	No Cost
One (1) prostate-specific antigen (PSA) test per Benefit Period, for Plan Participants fifty (50) years of age or older, and as recommended by a Physician if the Plan Participant is over forty (40) years of age. A second visit shall be permitted for follow-up treatment within sixty (60) days after the visit if related to a condition diagnosed or treated during the visit and recommended by a Physician.	No Cost	No Cost

EXAMINATIONS AND TESTING:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Colorectal Cancer Screening –		
• Fecal occult blood test: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	No Cost
• Flexible sigmoidoscopy: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Deductible & Coinsurance
• Colonoscopy: One (1) every ten (10) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Deductible & Coinsurance
• Other 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. Services we deem Investigational are not covered.	No Cost	Deductible & Coinsurance
Immunizations:	**PREFERRED CARE NETWORK**	**ALL OTHER PROVIDERS**
All state mandated immunizations including the complete basic immunization series as defined by the state health officer and required for school entry for children up to age six (6).	No Cost	Coinsurance
Immunizations recommended by the Plan Participant's Physician.	No Cost	Coinsurance
Screenings and Counseling:	**PREFERRED CARE NETWORK**	**ALL OTHER PROVIDERS**
Abdominal Aortic Aneurysm Screening: One per Benefit Period for Men ages 65-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Deductible & Coinsurance
Alcohol Misuse Screening and Counseling	No Cost	Deductible & Coinsurance
Aspirin Counseling	No Cost	No Cost
Blood Pressure Screening	No Cost	No Cost
Cholesterol Screening	No Cost	No Cost
Depression Screening	No Cost	No Cost
Type 2 Diabetes Screening	No Cost	No Cost
Diet Counseling	No Cost	No Cost
HIV Screening	No Cost	No Cost
Obesity Screening and Counseling	No Cost	No Cost
Sexually Transmitted Infection Counseling	No Cost	No Cost
Tobacco Use Screening	No Cost	Deductible & Coinsurance
Syphilis Screening	No Cost	No Cost

Covered Services for Women:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Counseling for - BRCA genetic testing and breast cancer chemoprevention.	No Cost	Deductible & Coinsurance
Routine Gynecologist / Obstetrician Visits. Additional visits recommended by the Plan Participant's Gynecologist / Obstetrician may be subject to Copayments, Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	No Cost
Mammography Examination - One (1) every twelve (12) months. Additional mammography examinations recommended by the Plan Participant's Physician may be subject to Copayments, Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	No Cost
Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; additional screenings will be subject to Deductible Amounts and Coinsurance percentages as shown in the Schedule of Benefits. (Bone Mass Measurement Benefits are located in the "Other Covered Services, Supplies or Equipment" section of this Benefit Plan)	No Cost	No Cost
Routine Pap Smear - One (1) per Benefit Period	No Cost	No Cost
Screenings – Chlamydia Infection and Gonorrhea	No Cost	No Cost
Breast Feeding Intervention	No Cost	No Cost
Folic Acid Supplements	No Cost	No Cost
Covered Services for Pregnant Women:	**PREFERRED CARE NETWORK**	**ALL OTHER PROVIDERS**
Anemia Screening	No Cost	No Cost
Bacteriuria Screening	No Cost	No Cost
Hepatitis B Screening	No Cost	No Cost
Rh Incompatibility Screening	No Cost	No Cost
Covered Services for Children:	**PREFERRED CARE NETWORK**	**ALL OTHER PROVIDERS**
Alcohol and Drug Use Assessments	No Cost	No Cost
Autism Screening: Ages 1-2	No Cost	Deductible & Coinsurance
Behavioral Assessments	No Cost	No Cost
Cervical Dysplasia Screening	No Cost	No Cost
Congenital Hypothyroidism Screening	No Cost	No Cost
Developmental Screening: Ages 0-3	No Cost	Deductible & Coinsurance
Dyslipidemia Screening	No Cost	No Cost
Hearing Screening: One per Benefit Period for Children Ages 0-21; additional screenings will be subject to Deductible Amounts and Coinsurance percentages as shown in the Schedule of Benefits.	No Cost	Deductible & Coinsurance
Height, Weight and Body Mass Index Measurements	No Cost	No Cost
Hematocrit or Hemoglobin Screening	No Cost	No Cost
Sickle Cell Screening for Newborns	No Cost	No Cost
HIV Screening	No Cost	No Cost
Lead Screening: One per Benefit Period for Ages 0-6; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	No Cost

Covered Services for Children:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Obesity Screening and Counseling	No Cost	No Cost
Oral Health Assessment	No Cost	No Cost
Phenylketonuria (PKU) for Newborns	No Cost	No Cost
Sexually Transmitted Infection Counseling	No Cost	No Cost
Tuberculosis Screening: One per Benefit Period for Ages 0-21; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	No Cost
Vision Screening: One per Benefit Period for Ages 0-21; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Deductible & Coinsurance

ARTICLE IX. MENTAL HEALTH BENEFITS

A. Treatment of Mental Health is covered subject to any limitations shown in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treatment of Mental Health do **not** include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.

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

ARTICLE X. SUBSTANCE ABUSE BENEFITS

A. Benefits for treatment of substance abuse are available only if shown as Covered Services in the Schedule of Benefits, and will be subject to any limitation shown. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Covered Services will be only those, which are for treatment for substance abuse and the resultant physiological and/or psychological dependency, which develops with continued use.

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 XI. ORAL SURGERY BENEFITS

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

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

B. Extraction of impacted teeth.

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

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

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

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

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

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

I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a 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 (TMJ) Disorders.

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

ARTICLE XII. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

The Claims Administrator's **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 Plan, all autologous procedures are considered transplants.

Solid organ and bone marrow transplants will not be covered unless a 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 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 a Blue Cross and Blue Shield of Louisiana (BCBSLA) Network facility, unless otherwise approved by the Claims Administrator in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities. To locate an approved transplant 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.

3. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

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

C. Solid Human Organ Transplants of the:

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), as specified below:

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 Authorization of Care Management.

These 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 XIII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

Plan Participants Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a patient covered as an Employee, Retiree or Dependent wife of an Employee or Retireewhose 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. Facility Services

   Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. 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. Benefits

   A Pregnancy Care Copayment, if shown in the Schedule of Benefits, applies to Covered Services rendered by Network Providers, for each covered pregnancy. The Plan Participant must pay all applicable Hospital Copayments, Deductibles and/or Coinsurance for any hospitalization related to the pregnancy, as shown in the Schedule of Benefits, in addition to any applicable Pregnancy Care Copayments. A Plan Participant obtaining care from a Non-Network Provider must pay the Hospital Deductible and Coinsurance and any Pregnancy Care Deductible and Coinsurance, if shown in the Schedule of Benefits.

B. Newborn Care

1. 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 48-hour or 96-hour 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 Your Plan Administrator.

2. For a Newborn who is Covered at Birth as a Dependent

   a. Medical and Surgical services rendered by a Physician, for treatment of illness, prematurity, post maturity, or congenital condition of a newborn and circumcision.

   b. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered under the Network Benefit Category only.

   c. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, prematurity, postmaturity, or congenital condition of a newborn. Charges for a well newborn which are billed separately from the mother's Hospital bill are not covered.

      i. 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.

      ii. An Inpatient Hospital Admission Copayment applies to the Admission of an ill newborn for treatment in a Network Hospital. We will provide Benefits of one hundred percent (100%) of the Allowable Charges for such treatment, less the Plan Participant's Copayment. Benefits for Hospital Covered Services for treatment of an ill newborn at a Non-Network Hospital will be determined by applying the Coinsurance shown in the Schedule of Benefits to Allowable Charges for those services.

ARTICLE XIV. REHABILITATIVE CARE BENEFITS

Rehabilitative Care Benefits will be available for Services provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, and/or Chiropractic Services. Benefits are available when services are rendered by a Provider licensed and practicing within the scope of his license. 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 Admission for the same or similar condition.

A. Occupational Therapy Benefits

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.

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

B. Physical Therapy Benefits

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 and if Benefits are provided for the following:

   a. To children with a diagnosed developmental disability pursuant to the Plan Participant's plan of care.

   b. As part of a Home Health Care agency pursuant to the Plan Participant'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.

   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 Benefits

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.

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

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

D. Chiropractic Services Benefits

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.

2. Chiropractic Services are 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. 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 XV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

The following services are available to a Plan Participant, subject to other limitations shown in the Schedule of Benefits.

A. Ambulance Service Benefits

1. The following Ambulance Services for local transportation are covered when Medically Necessary:

   a. to or from the nearest Hospital that can provide services appropriate to a Plan Participant's condition for an illness or injury requiring Hospital care;

   b. to the nearest Hospital or neonatal Special Care Unit for newborn infants for treatment of illnesses, injuries, congenital birth defects and complications of premature birth which require that level of care;

   c. 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.

2. Benefits for air Ambulance Services are available only if this type of Ambulance Service is requested by policing or medical authorities at the site in an Emergency situation or if the Plan Participant is in a location that cannot be reached by a ground ambulance.

3. In a non-Emergency situation, air Ambulance Service is not covered unless the Plan Participant requests and receives Authorization from the Claims Administrator prior to the service being rendered.

4. If a Plan Participant pays a periodic fee to an ambulance membership organization with which the Claims Administrator does not have a Provider Agreement, Benefits for expenses incurred by the Plan Participant for 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 Claims Administrator and the ambulance organization, Benefits will be based on the Allowable Charge.

5. No Benefits are available if transportation is provided for the 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 when rendered or prescribed by a Physician or Allied Health Professional is covered.

C. Autism Spectrum Disorders (ASD)

ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care.
Plan Participants who have not yet reached their 17th birthday are eligible for Applied Behavior Analysis, when Company determines it is Medically Necessary. Applied Behavior Analysis is not covered for Plan Participants age seventeen (17) and older.

ASD Benefits are subject to the Co-payments, Deductibles, and Coinsurance amounts that are applicable to the Benefits obtained. (Example: A Plan Participant obtains speech therapy for treatment of ASD. Plan Participant will pay the applicable Copayment, Deductible or Coinsurance amount shown on the Schedule of Benefits for speech therapy.

D. 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.

4. Deductible, coinsurance and/or copayment amounts are applicable.

E. 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 attending Physician, if applicable, and will be subject to any Deductible Amounts, Copayments and Coinsurance.

F. Cleft Lip and Cleft Palate Services

Covered Services include the following:

1. Oral and facial Surgery, surgical management, and follow-up care.

2. Prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

3. Orthodontic treatment and management.

4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

5. Speech-language evaluation and therapy.

6. Audiological assessments and amplification devices.

7. Otolaryngology treatment and management.

8. Psychological assessment and counseling.

9. Genetic assessment and counseling for patient and parents.

G. Clinical Trial Participation

1. This Plan shall provide coverage for patient costs incurred as a result of a treatment being provided in accordance with a clinical trial for cancer. Coverage will be subject to any applicable Copayment, Deductible, or Coinsurance amounts shown in the Schedule of Benefits.

2. The following services are not covered:

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

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

c. Investigational drugs or devices; and/or

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

3. Investigational 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 for the prevention or early detection of cancer.

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

c. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:

(1) One of the United States National Institutes of Health.

(2) A cooperative Group funded by one of the National Institutes of Health.

(3) The FDA, in the form of an Investigational new drug application.

(4) The United States Department of Veterans Affairs.

(5) The United States Department of Defense.

(6) A federally funded general clinical research center.

(7) The Coalition of National Cancer Cooperative Groups.

d. 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.

e. 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.

f. There must be no clearly superior, non-Investigational approach.

g. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-Investigational alternative.

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

H. Colorectal Cancer Screening Benefits

Benefits are available for routine colorectal cancer screenings. Routine colorectal cancer screening shall mean a fecal occult blood test, flexible sigmoidoscopy, or colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by the Claims Administrator to be Investigational.

I. Diabetes Coverage

1. Coverage is available for the equipment, supplies, and Outpatient self-treatment training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Plan Participant's Physician.

2. A one-time evaluation and training program per Plan Participant 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.

3. Diabetes Plus Program

    Services are available when provided by Our Lady of the Lake Medical Center and authorized by Case Management. Allowance for services is determined by Case Management.

    a. initial assessment

    b. class (5 day series)

    c. individual appointment with registered dietitian

J. Dietician Visits

Benefits are available for outpatient visits to registered dieticians, subject to payment of any applicable Deductible and Coinsurance shown on the Schedule of Benefits. Benefits are limited to a specific dollar amount of Allowable Charges per Benefit Period. The Plan Participant will be responsible for all amounts in excess of the amount shown on the Schedule of Benefits. Charges in excess of this amount are considered Non-Covered Services and will not accrue to the Plan Participant's Out-of-Pocket Amount. Dietician visits for diabetics are not covered under this Benefit. Dietician visits for diabetics may be available under a separate Benefit for diabetes self-treatment training and education.

K. Disposable Medical Equipment or Supplies

Disposable medical equipment or supplies related to and necessary for the administration of Prescription Drugs, such as syringes and needles, and other disposable medical equipment or supplies, which have a primary medical purpose, are covered and will be subject to reasonable quantity limits as determined by the Claims Administrator. Benefits for these supplies will be determined by applying the same Coinsurance percentage applicable to Durable Medical Equipment, to the Allowable Charges for these supplies.

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances are covered at the 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 rental Allowable Charge (but not to exceed the purchase Allowable Charge).

   (2) At the Plan's 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.

d. 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 the Claims Administrator Authorize. These Benefits will be subject to the following:

a. There is no coverage for fitting or an adjustment 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. The Plan 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

Benefits will be available for the purchase of Prosthetic Appliances Authorized by the Claims Administrator 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.

b. Repair or replacement of the Prosthetic Appliance is covered only after a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Plan 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.

M. Emergency Medical Services (Out-of-Area)

a. A Plan Participant must pay an emergency room Copayment, shown in the Schedule of Benefits, for each visit the Plan Participant makes to a Hospital or Allied Health Facility for Emergency Medical Services while outside his Service Area.

2. The emergency room Copayment is waived if the visit results in an Inpatient Hospital Admission.

3. A Plan Participant must pay a Physician's Copayment for each visit the Plan Participant makes to a Physician's office for Emergency Medical Services while outside his Service Area.

N. Hearing Aid Benefits

Benefits are available for hearing aids for covered Plan Participants age seventeen (17) and under. This Benefit is limited to one hearing aid, per ear, in a thirty-six (36) month period. The hearing aid must be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

The Plan will pay up to the Allowable Charge for this Benefit. The Plan may increase their Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge. In no event will the Plan pay more than one thousand four hundred dollars ($1,400.00) per hearing aid, per ear, in a thirty-six (36) month period. If the Plan Participant purchases a hearing aid that costs more than one thousand four hundred dollars ($1,400.00),

the Plan Participant is responsible for all amounts above one thousand four hundred dollars ($1,400.00). This Benefit is not subject to Coinsurance or Deductible Amounts.

Eligible implantable bone conduction hearing aids are not subject to the above limitation and provisions. They are covered the same as any other service or supply, subject to any applicable Copayment, Coinsurance and Deductible Amounts.

O. Hospice and Home Health Care Benefits

1. Hospice Care is covered up to the maximum number of days per Benefit Period shown in the Schedule of Benefits.

2. Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered, for the maximum number of visits per Benefit Period shown in the Schedule of Benefits.

P. Interpreter Expenses for the Hearing Impaired

Services performed by a qualified interpreter/transliterator are covered when the Plan Participant needs such services in connection with medical treatment or diagnostic Consultations performed by a Physician or Allied Health Professional, if the services are required because of the Plan Participant's hearing impairment or his failure to understand or otherwise communicate in spoken language. Services rendered by a family member are not covered.

Q. Low Protein Food Products for Treatment of Inherited Metabolic Diseases

Benefits are available for low protein food products for treatment of certain Inherited Metabolic Diseases. "Inherited Metabolic Disease" shall mean a disease caused by an inherited abnormality of body chemistry. "Low Protein Food Products" shall mean those foods that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low Protein Food Products shall not include natural foods that are naturally low in protein. Benefits for Low Protein Food Products are limited to the treatment of the following diseases:

Phenylketonuria (PKU);
Maple Syrup Urine Disease (MSUD);
Methylmalonic Acidemia (MMA);
Isovaleric Acidemia (IVA);
Propionic Acidemia;
Glutaric Acidemia;
Urea Cycle Defects;
Tyrosinemia.

Benefits shall not exceed two-hundred dollars ($200.00) per month, and are subject to applicable Deductible Amounts, Coinsurance, and/or Copayments as shown on the Schedule of Benefits. The Plan Participant is responsible for all amounts above two-hundred dollars ($200.00) per month. Charges over two-hundred dollars ($200.00) per month are non-covered charges and do not accrue to the Plan Participant's Out-of-Pocket Amount.

R. Nutritional Education Program

Services are available when provided by Our Lady of the Lake Medical Center and Authorized by Case management. Allowance for services is determined by Case management. Initial nutritional assessment (1 hour) and subsequent counseling visits (1/2 hour) related to diet & disease for:

- Crohn's disease
- Hypercholesterolemia
- Hyperlipidemia
- Hypoglycemia

- Anemia
- Obesity
- Malnutrition

S. Permanent Sterilization Procedures and Contraceptive Devices

Benefits are available for surgical procedures and/or contraceptive devices that result in permanent sterilization, including tubal ligation, vasectomy, and hysteroscopic placement of micro-inserts into the fallopian tubes. Benefits are available for contraceptive intrauterine devices (IUDs), including the insertion and removal of such devices.

T. Prescription Drugs

If coverage is available for Prescription Drugs, all Prescription Drugs approved for self-administration (e.g. oral and self-injectable drugs) must be obtained through the Prescription Drug Benefits section of this Benefit Plan.

U. Private Duty Nursing Services

1. Coverage is available to a Plan Participant for Private Duty Nursing Services as shown in the Schedule of Benefits when performed on an Outpatient basis and when the nurse is not related to the Plan Participant by blood, marriage or adoption.

2. Private Duty Nursing Services are covered at the Coinsurance level and are subject to the limitations shown in the Schedule of Benefits.

3. Inpatient Private Duty Nursing Services are not covered.

V. Sleep Studies

Medically Necessary sleep studies and associated professional Claims are eligible for coverage when a sleep study is obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM).

W. Surgery for Refractive Errors of the Eye

Benefits are available for in-network providers only.

X. Urgent Care Center Benefits

An Urgent Care Center Copayment, shown in the Schedule of Benefits, applies to each visit to an Urgent Care Center that is in Our Network. A Plan Participant receiving care from a Non-Network Urgent Care Center is responsible for the Coinsurance percentage shown in the Schedule of Benefits subject to any limitations or maximum Benefits.

Y. 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.

3. Benefits may be available for glasses or contact lenses if shown as a Covered Service in the Schedule of Benefits, and are subject to any limitation shown.

ARTICLE XVI. CARE MANAGEMENT

A. Authorization of Admissions

1. Elective Admissions

a. The Plan Participant is responsible for ensuring that his Provider contacts 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.

b. If a request for Authorization is denied, the Admission is not covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission for which Authorization was denied.

c. If Authorization is not requested prior to the services being rendered, in addition to any Deductible Amount and Coinsurance amount required in this Benefit Plan, the Plan Participant will be responsible for all charges for Hospital services not specifically listed as Covered Services during the Admission and for the penalty amount shown in the Schedule of Benefits. Additionally, all days not Authorized will be reviewed for Medical Necessity and could be denied.

d. 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 will not apply toward satisfying the Out-of-Pocket Amount.

2. Emergency Admissions

a. 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.

b. If Authorization is denied, the Admission will not be covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission.

c. If Authorization is not requested, in addition to any Deductible Amount and Coinsurance amount required in this Benefit Plan, the Plan Participant will be responsible for all charges for Hospital services not specifically listed as Covered Services during the Admission and for the penalty amount shown in the Schedule of Benefits. Additionally, all days not Authorized will be reviewed for Medical Necessity and could be denied.

d. Additional amounts the Plan Participant is responsible for because Authorization of an Emergency Admission was denied or not requested will not apply toward the Out-of-Pocket Amount.

3. Concurrent Review

a. 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.

b. 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 Company will notify the Plan Participant and his Providers, in writing, that the request is denied and no additional days are Authorized.

c. 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.

d. 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 identification (ID) card.

If Authorization is not requested prior to a listed service being rendered or a listed supply being received, Claims Administrator will have the right to determine if the service or supply was Medically Necessary. If the service or supply was Medically Necessary, Benefits will be provided based on the participating status of the Provider of the service or supply. If a contracted Provider in the Preferred Network fails to obtain a required Authorization, the Plan will reduce his Benefit payment by thirty percent (30%) of the Allowable Charge. This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Preferred Care Provider is responsible for all charges not covered and for the penalty amount. The Plan Participant remains responsible for his Copayment, Deductible amount and applicable Coinsurance percentage. If a service or supply was not Medically Necessary, the service or supply is not covered.

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 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 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 Plans 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

   Blue Cross Blue Shield of Louisiana's Disease Management programs are committed to improving the quality of care for its 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. Blue Cross and Blue Shield of Louisiana is dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant.

C. Case Management

1. The Plan Participant may qualify for Case Management Services, at Our 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.

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 the Plan Participant or for any other Plan Participant: The provision of Case Management services to one Plan Participant will not entitle the Plan Participant or any other Plan Participant to Case Management services or be construed as a waiver of the Claims Administrator's rights 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 Contract, 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 a 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's, 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 the 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 Benefit 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 XVII. 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:**

   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 Plan. Benefits are not payable for services a Plan Participant has no obligation to pay, or for which no charge would be made if a Plan Participant had no health 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 the Plan Participant's Effective Date;

c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license.

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

e. paid or payable under Medicare Parts A or B when a 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 the Claims Administrator's 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 L.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. rendered by a Provider who is the Plan Participant's spouse, child, stepchild, parent, stepparent or grandparent.

5. Services in the following categories:

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

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

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

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

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

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

   a. rhinoplasty;

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

   c. gynecomastia;

   d. breast enlargement or breast reduction, unless the estimated weight to be removed during breast reduction is greater than five hundred (500) grams excess breast tissue per breast to be reduced; and the patient is **not** more than thirty percent (30%) over ideal body weight; and the Plan Participant has one of the following associated symptoms:

      (1) back, neck, or shoulder pain;

      (2) parenthesis of hands or arms in ulnar distribution; and/or;

(3) permanent shoulder grooving from bras straps;

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

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

g. diastasis recti;

h. biofeedback;

i. lifestyle/habit changing clinics and/or programs;

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

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

l. recreational therapy; and/or

m. primarily to enhance athletic abilities.

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), unless shown as covered in the Schedule of Benefits;

   b. eye exercises, visual training, or orthoptics;

   c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;

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

   e. 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. obesity or morbid obesity, regardless of Medical Necessity.

10. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.

11. Services or supplies for the treatment of eating disorders, unless otherwise required by law.

12. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us.

13. Prescription Drugs that the Claims Administrator determines are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits:

    a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Meridia®, Xenical®), or medications used to enhance athletic performance;

    b. any medication not proven effective in general medical practice;

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

    d. fertility drugs;

    e. minerals and vitamins, except for vitamins requiring a prescription for dispensation;

    f. nutritional or dietary supplements, or herbal supplements and treatments;

    g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available;

    h. contraceptive drugs;

    i. contraceptive devices that do not result in permanent sterilization, except for covered intrauterine devices (IUDs);

    j. refills in excess of the number specified by the Physician or the dispensing limitation described in this Benefit Plan, or a refill prior to seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription;

    k. smoking cessation programs, supplies, prescription or over-the-counter drugs (except Zyban). Smoking cessation screening and counseling are covered under the Preventive or Wellness Care section of this plan;

    l. compounded drugs that exhibit any of the following characteristics: 1) are similar to a commercially available product; 2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval; 3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being administered topically); 4) compounded drugs that contain drug products or components of such drug products that

have been withdrawn or removed from the market for reasons of safety; or 5) compounded prescriptions whose only ingredients do not require a prescription;

m. drugs for non-Covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®);

n. Prescription Drugs filled prior to the Plan Participant's Effective Date or after a Plan Participant' s coverage ends;

o. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage;

p. Prescription Drugs related to a non-Covered Service;

q. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®);

r. 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;

s. growth hormone therapy, except for chronic renal insufficiency, AID's wasting, and Turners Syndrome, unless an endocrinologist confirms growth hormone deficiency with abnormal provocative stimulation testing;

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

u. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Plan Participant misrepresentation to that prescriber. Limitation may include, but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy; or

14. Coverage is not available for Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) when obtained from a Physician or other Provider who is not contracted with the Claims Administrator's pharmacy Benefit manager. Injectable drugs that can be self-administered are not covered when obtained from an infusion therapy provider, unless prescribed in conjunction with intravenous infusions provided by the infusion therapy provider.

15. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Plan Participant's Coinsurance and the Plan's financial responsibility. The Plan will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Plan Participant's Copayment, in which case, the Plan Participant must pay the Prescription Drug cost and sales tax.

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

17. Charges for telephone or e-mail Consultations between a Provider and a Plan Participant, failure to keep a scheduled visit, completion of a Claim form, or to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

18. 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.

19. Any abortion other than to save the life of the mother.

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

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

22. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.

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

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

25. Services, supplies or treatment for cosmetic purposes, Cosmetic Surgery and any complications of Cosmetic Surgery, unless required for a Congenital Anomaly.

26. Dental Care and Treatment and dental appliances except as specified in this Benefit Plan under Oral Surgery Benefits.

27. 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.

28. 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.

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

30. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Benefit Plan for diabetes; diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.

31. 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.

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

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

34. Hospital charges for a well newborn.

35. Services or supplies for the treatment of substance abuse, unless shown as Covered Services in the Schedule of Benefits.

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

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

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

39. Paternity tests and tests performed for legal purposes.

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

41. Reversal of a voluntary sterilization procedure.

42. Services or supplies for the prophylactic storage of cord blood.

43. Pain rehabilitation or pain control programs.

44. Applied Behavior Analysis (ABA) that the Claims Administrator 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 a behavior analyst by the Behavior Analyst Certification Board or rendered by a Provider that has not provided, to the satisfaction of the Claims Administrator, documented evidence of equivalent education, professional training, and supervised experience in ABA.

ARTICLE XVIII. COBRA CONTINUATION OF COVERAGE

Benefits will be paid if required by the Uniformed Services Employment and Reemployment Rights Act of 1994 as amended (USERRA).

The following provisions are applicable only if the employer is subject to the Consolidated Omnibus Reconciliation Act of 1985 and any amendments thereto. See the Group Human Resources Manager for details about COBRA.

PLAN PARTICIPANTS MUST FOLLOW ALL NOTICE AND TIME PERIOD REQUIREMENTS OR LOSE THE RIGHT TO COBRA CONTINUATION COVERAGE.

If the Group requires shorter time periods than those stated herein, the shorter time periods of the Group apply.

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

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

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

- Termination of employment of a covered Employee for reasons other than gross misconduct;
- Loss of eligibility by a covered Employee due to a reduction in the number of work hours of the covered employee;
- Death of a covered Employees;
- A Dependent spouse’s divorce or legal separation from a covered Employees;

- The covered Employee becomes entitled to Medicare Benefits resulting in the loss of coverage for Dependents;

- A Dependent child ceases to be an Eligible Dependent under the terms of this Benefit Plan; or

- The employer's Title 11 bankruptcy proceeding, with respect to covered employees who retired from the employer at any time.

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

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

A Plan Participant may be required to pay the applicable premium for continued coverage plus an amount to cover administrative expenses. A Plan Participant may be eligible for a premium subsidy through the American Recovery and Reinvestment Act of 2009 (ARRA). See the Human Resources Manager for details. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Plan Participant otherwise would lose coverage under the Group health plan (the termination date); and

- ends sixty (60) days after the termination date or sixty (60) days after the Plan Participant is notified of their right to continue coverage.

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

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

- Eighteen (18) months after the termination date in the case of termination of employment or reduction in work hours. When the qualifying event is the end of employment or reduction of the Employee's work hours, and the Employee became entitled to Medicare Benefits less than eighteen (18) months before the qualifying event, COBRA continuation of coverage for qualified beneficiaries other than the Employee lasts the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event.

  Note: The eighteen (18) months may be extended to twenty-nine (29) months if a qualified beneficiary who is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) before the first day of COBRA coverage or becomes disabled during the first sixty (60) days of COBRA coverage. This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. The qualified beneficiary must notify the Group of the disability determination before the end of the initial eighteen (18) month COBRA period and within sixty (6) days from:

  - the date of the notice from the Social Security Administration of the determination of disability; or

  - the date of the qualifying event;

  The qualified beneficiary must also notify the Group within thirty (30) days of any final determination that the qualified beneficiary is no longer disabled. In this case, coverage will end the earliest of twenty-nine (29) months after the date of the qualifying event or the first day of the month that begins more than thirty (30) days after a final determination that the qualified beneficiary is no longer disabled (as determined under the Social Security Act) subject to the original eighteen (18) months of COBRA coverage; or

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

  Note: Special rules may apply for the duration of coverage under COBRA for certain Retirees and their Dependents who lose coverage because of an employer's bankruptcy, which is a "qualifying event." In this event, certain retirees and certain Dependents of retirees who are deceased at the time of the qualifying event, may elect lifetime COBRA coverage as of the date of the bankruptcy proceeding. Otherwise, eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including but not limited to: the employer ceases to provide any Group health plan to any employees or the qualified beneficiaries fail to pay the required premiums or become covered under another employer's Group health plan that does not exclude or limit Benefits for a qualified beneficiary's Pre-Existing Conditions.

Second Qualifying Event:

If a Employee and Dependent(s) experience another qualifying event while receiving eighteen (18) months of COBRA continuation of coverage, the Dependents who were qualified beneficiaries at the time of the first qualifying event, may qualify for up to eighteen (18) additional months of COBRA continuation of coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Group within sixty (60) days of the second qualifying event. This extension may be available to Dependents receiving continuation of coverage if:

- the Employee or former Employee dies;
- the Employee or former Employee becomes entitled to Medicare (under Part A, Part B, or both);
- the Employee or former Employee and Dependent spouse divorces;
- the Dependent child is no longer eligible under the Benefit Plan as a Dependent.

The second qualifying event is applicable only if the event would have caused the Dependent to lose coverage under the plan had the first qualifying event not occurred.

Note: Special Second Election Period for Certain Trade-Displaced Individuals Who Did Not Elect COBRA Coverage: Special COBRA rights apply to employees who lost health coverage as a result of a termination or reduction of hours and who qualify for a "trade adjustment allowance (TAA)" or "alternative trade adjustment assistance (ATAA)" under a federal law called the Trade Act of2002 and as amended by ARRA. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain Dependents (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. The sixty (60) day period beginning on the first day of the month in which an eligible employee becomes a TAA or ATAA eligible individual, but only if the election is made within six (6) months immediately after the eligible Employee's Group health plan coverage ended. If the Employee qualifies or may qualify for assistance under the Trade Act of2002, and as amended by ARRA, the Employee should contact the Group's Human Resources Manager for additional information. THE EMPLOYEEMUST CONTACT THE GROUP'S HUMAN RESOURCES MANAGER PROMPTLY AFTER QUALIFYING FOR ASSISTANCE UNDER

THE TRADE ACT OF 2002, AND AS AMENDED BY ARRA,OR THE EMPLOYEEWILL LOSE HIS SPECIAL COBRA RIGHTS.

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 it's 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, the Claims Administrator does 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 that 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, (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 or Plan Participant or their 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 or as a Dependent 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 We need. We 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 We need 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. This Plan may pay that amount to the organization that 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 This Plan from further liability. The term “payment made” includes providing Benefits in the form of services, in which case the payment made will be deemed the reasonable cash value of any Benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments that this Plan made is more than it should have paid under this COB section, this Plan may recover the excess. It may get such recovery or payment from one or more of:

1. The persons it has paid or for whom We have 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/POLICYHOLDER, AND ALL PLAN PARTICIPANTS.

The Group enters into this Benefit Plan on behalf of the eligible individuals enrolling under this Benefit Plan. Acceptance of this Benefit Plan by the Group is acceptance by and binding upon those who enroll as Plan Participants and Dependents.

A. This 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. To the extent that 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 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 that We specifically undertake herein. To the extent that 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 Plan will indemnify and hold the Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Plan's failure to do so.

2. 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 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 the Plan Participant's care or treatment.

3. 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 Plan Participant'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.

4. 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 Benefit 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 the Benefit Plan for the Group's covered Employees. At the direction of 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 Employees. 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 Benefit 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.

3. The Plan may set a minimum dollar amount for claims to be reviewed for possible Pre-Existing Conditions.

E. Termination of a Plan Participant's Coverage

1. The Plan may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed or covered Plan Participant, shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective date of coverage or terminated within three (3) years of the Plan Participant's Effective Date, for fraud or intentional misrepresentation of material fact. The Plan will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section.

2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, a Employee's coverage terminates as provided below:

    a. The Employee's coverage and that of all his Dependents automatically, and without notice, terminates at the end of the billing cycle in which the Employee ceases to be eligible.

    b. The coverage of the Employee's spouse will terminate automatically and without notice at the end of the billing cycle for which premiums have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.

    c. The coverage of a Dependent will terminate automatically, and without notice, at the end of the billing cycle in which the Dependent ceases to be an eligible Dependent, if premiums have been paid through that period.

    d. Upon the death of an Employee or Retiree the surviving spouse and/or dependents are eligible to continue coverage as long as they are receiving a survivor's benefit under the Employees' Retirement System of the City of Baton Rouge and Parish of East Baton Rouge or Municipal Police Employees' Retirement System. The surviving spouse and/or dependents must have had coverage prior to the date of death.

        - The surviving spouse is eligible to continue coverage as long as he/she is receiving a survivor's benefit under either retirement system. The surviving spouse will lose coverage if they remarry or otherwise lose eligibility.
        -

    The surviving dependent children are eligible to continue coverage as long as they are receiving a survivor's benefit under either retirement system or if covered as a dependent of a surviving spouse.

3. In the event the Group cancels this Benefit Plan, such cancellation or termination alone will operate to end all rights of the Plan Participant to Benefits under the terms of this Benefit Plan as of the Effective Date of such cancellation or termination. The Group shall have the obligation to notify its Plan Participants, participants, and beneficiaries of such cancellation or termination. The Claims Administrator shall have no such obligation of notification at the Plan Participant level.
4. In the event of the occurrence of the provisions of paragraphs a., b., c. or d. above, if the Plan Participant is an Inpatient in a Hospital on the date coverage ends medical Benefits in connection with the Admission for

that patient will end at the end of that Admission, or upon reaching any Benefit limitations set in this Benefit Plan, whichever occurs first.

5. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Plan Participant for Covered Services rendered after the date of cancellation or termination of a Plan Participant's coverage.

6. The Claims Administrator reserves the right to automatically change the Plan Participant's class of coverage to reflect when no more children or grandchildren are covered under this Benefit Plan.

7. Cancellation or termination will be effective at midnight on the last day of the billing cycle. Billing cycles are from the first to the end of the month or from the 15th of the month to the 14th of the following month.

8. When the Group's coverage ends because the plan ceases to exist or COBRA is exhausted, the Louisiana Health Plan (LHP) can be contacted regarding possible health coverage for eligible individuals. For detailed information regarding price and available Benefits, Plan Participants may write to LHP at P.O. Drawer 83880, Baton Rouge, LA 70884-3880 or may call LHP at (225) 926-6245 or (800) 736-0947. Timeliness of communication with LHP is important.

9. Employees on Military Leave

   a. Employees going into or returning from military service may elect to continue plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances.

      These rights apply only to Employees and their Dependents covered under the plan immediately before leaving for military service.

      (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

         (a) The twenty-four (24) month period beginning on the date on which the person's absence begins; or

         (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

      (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Benefit Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

      (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during the performance of uniformed service.

   If You wish to elect this coverage or obtain more detailed information, contact the Plan Administrator,

   Attention: Director of Human Resources
   City of Baton Rouge/East Baton Rouge Parish
   1755 Florida Street
   Baton Rouge, LA 70802
   225-389-3134

   You may also have continuation rights under USERRA. In general, You must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect

USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

F. 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 Plan. The Plan encourages Providers to file claims in a form acceptable to the Claims Administrator 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 filed or expense actually incurred as a result of the service or treatment rendered.

2. Most Plan Participants with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Plan Participant. However, if the Plan Participant must file a claim to access their Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to the Claims Administrator, may require the signature of the dispensing pharmacist. The claim form should then be sent to the Claims Administrator Pharmacy Benefit Manager, whose telephone number should be found on the Plan Participant's ID card.

G. Legal Action

No lawsuit may be filed:

1. any earlier than the first sixty (60) days after notice of Claim has been given; or

2. 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. A Plan Participant's rights and Benefits 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 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, 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 Plan or the Claims Administrator liable to any third party to whom a Plan Participant may be liable to for the cost of medical care, treatment, or services.

2. The Plan reserves the right to pay Preferred Care Network Providers, and/or Providers in the Blue Cross and Blue Shield of Louisiana Participating Provider Network directly instead of paying the Plan Participant.

J. Plan Participant/Provider Relationship

1. The choice of a Provider is solely the Plan Participants.

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 for Covered Services that the Plan Participant receives. The Plan and the Claims Administrator will not be held liable for any act or

omission of any Provider, or for any Claim or demand because 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 Claims Administrator has 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 Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

K. 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 U.S. or of the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute or regulation.

L. 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 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, this 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 the Plan's 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 Plan's Allowable Charge.

M. 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.

N. 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 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 L.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 when 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. We will be entitled to such reimbursement even if the settlement does not mention or excludes payment for health care expenses.

O. 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 facilitating enforcement of the Plan's rights, and will take no action prejudicing the Plan'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 is required to notify the Plan of any Accidental Injury.

P. Right of Recovery

Whenever any payment for Covered Services has been made by the Plan in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, 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 Plan reserves the right to deduct from any pending Claim for payment under this Benefit Plan any amounts the Plan Participant or the Provider owes the Plan.

Q. 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.

R. 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 a claims administration services agreement with the Group based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Plan Administrator for any of Blue Cross and Blue Shield of Louisiana's obligations to the Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of this claims administration agreement.

S. HIPAA Certificates of Creditable Coverage

The Claims Administrator shall provide to Plan Participants free of charge, a written certification of the Plan Participant's coverage under this Benefit Plan (HIPAA Certificate of Creditable Coverage) under the following circumstances:

1. The Claims Administrator will automatically issue a HIPAA Certificate of Creditable Coverage to:

    a. An individual who is a qualified beneficiary entitled to COBRA continuation of coverage.

    b. An individual ceasing to be covered under this Benefit Plan.

    c. An individual who is a qualified beneficiary and has elected COBRA continuation of coverage that has ended.

2. The Claims Administrator will issue a HIPAA Certificate of Creditable Coverage upon request to an individual within twenty-four (24) months after coverage ceases.

3. To receive written guidelines on requesting and receiving a HIPAA Certificate of Creditable Coverage, the Plan Participant should contact The Claims Administrator's customer service department at the phone number shown on his ID card.

T. Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage

The Claims Administrator shall provide to certain Plan Participants who have Prescription Drug coverage under this Plan a written certification that their Prescription Drug coverage under this Plan is either creditable or non-creditable. Coverage is deemed creditable if it is at least as good as the standard Medicare Part D prescription drug Benefit. The Claims Administrator will provide these Certificates to covered Group Plan Participants who are eligible for Medicare Part D based upon enrollment data. The Plan Administrator is responsible for providing a certificate to applicants prior to the Effective Date of coverage for new Medicare-eligible persons that join this Plan.

The Claims Administrator will provide Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to Covered Plan Participants at the following times, or as designated by law:

1. Prior to the Medicare Part D Annual Coordinated Election Period;

2. Prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D;

3. Whenever Prescription Drug coverage under this Benefit Plan ends;

4. Whenever Prescription Drug coverage under this Plan changes so that it is no longer creditable or becomes creditable; and/or

5. Upon a Medicare beneficiary's request.

U. Out-of-Area Services

The Company/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 healthcare providers. Claims Administrator's payment practices in both instances are described below.

1. BlueCard® Program

   Under the BlueCard Program, when Plan Participants access covered healthcare services within the geographic area served by a Host Blue, 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 healthcare providers.

   Whenever Plan Participants access covered healthcare 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 healthcare services from Participating Providers is calculated based on the lower of:

   - The billed covered charges for your covered services; or
   - The negotiated price that the Host Blue makes available to the Plan.

   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, Claims Administrator would then calculate your liability for any covered healthcare 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 healthcare 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 healthcare providers, the amount Plan Participant pays for such services is described below.

   a. Plan Participant Liability Calculation

      When covered healthcare services are provided outside of Claims Administrator's service area by non-participating healthcare providers, the amounts a Plan Participant pays for such services will generally be based on either the Host Blue's non-participating healthcare 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 healthcare 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 healthcare 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 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 healthcare 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 the Plan will make for the covered services as set forth in this paragraph.

V. Continued Coverage During a Leave of Absence

Other Employer-Approved Leave of Absence

When an Employee has been granted a documented, approved leave of absence by the employer Group, the Plan will maintain coverage for the Employee and any Covered Dependents for a period not to exceed ninety (90) days. Premiums must be paid and Employee must remain a bona fide Employee of Group during the approved leave period. Group will provide Company with proof of the documented leave, upon request. If Group terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan

W. Compliance with HIPAA Privacy Standards

Certain Plan Participants 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 Plan Participant 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 Plan Participants 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 Plan Participants 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, "Plan Participants of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employers.

a. Updates Required. The Employer shall amend the plan promptly with respect to any changes in the Plan Participants of its workforce who are authorized to receive Protected Health Information.

b. Use and Disclosure Restricted. An authorized Plan Participant 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 Plan Participant 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 Plan Participants in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Plan 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 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 Plan Participant of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

The following Plan Participants of the CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE 's workforce are designated as authorized to receive Protected Health Information from CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE ("the Plan") in order to perform their duties with respect to the Plan: Human Resources Payroll & Benefits Division.

X. 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.

3. 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 the care or services they receive from the Claims Administrator or one of its Providers. If a Plan Participant wants to register a Complaint or file a formal written Grievance about the Claims Administrator or a Provider, they should refer to the procedures below.

A Plan Participant may be unhappy about decisions the Claims Administrator makes on behalf of the Plan regarding covered services. The Plan considers a Plan Participant's request to change the coverage decision as an Appeal. The Plan defines an Appeal as a request from a Plan Participant or 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 based on adverse determinations of Medical Necessity, or Benefit determinations.

Your appeal rights are outlined below, after the Complaint and Grievance procedure. In addition to the Appeals rights, the Plan Participant's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of the Claims Administrator's coverage decisions when they concern medical necessity determinations.

COMPLAINT AND GRIEVANCE PROCEDURE

A Complaint is an oral expression of dissatisfaction with the Claims Administrator or with Provider services. A quality of care concern addresses the appropriateness of care given to a Plan Participant. A quality of service concern addresses the Claims Administrator's services, access, availability or attitude and those of the Claims Administrator's network Providers.

TO REGISTER A COMPLAINT

Call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370. The Claim Administrator will attempt to resolve a Plan Participant's complaint at the time of their call.

TO FILE A FORMAL GRIEVANCE

A Grievance is a written expression of dissatisfaction with the Claims Administrator or with Provider services. 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. The Claims Administrator's customer service department will assist the Plan Participant if necessary. Send written Grievances to:

Blue Cross and Blue Shield of Louisiana
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 Plan Participant's written Grievance. If the Plan Participant is not happy with the Claims Administrator's handling of their Grievance, the Plan Participant has the right to elevate their Grievance to the second and final level. The Claims Administrator must receive the Plan Participant's request for a second level Grievance no later than sixty (60) calendar days from the date the Claims Administrator notifies the Plan Participant of the answer to the first level Grievance. Grievances received after this date will not be considered. A separate panel reviews each level of Grievance.

INFORMAL RECONSIDERATION

An Informal Reconsideration is the Plan Participant's 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 that the Claims Administrator has made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion. An 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. Once the Informal Reconsideration is finalized, the Plan Participant will be advised of any appeal rights that may exist.

MULTIPLE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED, AT ANY LEVEL OF REVIEW.

APPEAL PROCEDURES

The Plan Participant may submit appeals or communicate with the Claims Administrator regarding any Appeal by writing to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

If the Plan Participant has questions or need assistance putting the Appeal in writing, the Plan Participant may call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370. The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

APPEAL PROCESS

The Claims Administrator will distinguish the Plan Participant's Appeal as an administrative Appeal, a Medical Necessity Appeal or an Investigational Appeal. The procedure has two (2) levels of appeal, the first by the Claims

Administrator or its designee, and the second by the Plan Administrator, CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE Health Plan. 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 covered person'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 internal review of a denial. The authorized representative may be the Plan Participant's treating Provider.

Persons not involved in previous decision regarding the 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 Participant's Claims will review Medical Necessity Appeals.

FIRST LEVEL OF STANDARD APPEAL

The first level of appeal is a process where the Claims Administrator reviews denied Claims that are not of an urgent nature. The Plan Participant, their authorized representative, or a Provider acting on the Plan Participant's behalf, must submit a request to Appeal the decision in writing. The Plan Participant has one hundred and eighty (180) days following the receipt of an adverse benefit determination to request an Appeal. Requests submitted to the Claims Administrator after one hundred and eighty (180) days of the denial will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. Health care professionals, including a Physician not previously involved in the initial decision, will review all Appeals of Medical Necessity and Investigational denials. If the Claims Administrator changes their original decision at the appeal level, the Claims Administrator will process the Plan Participant's claim and notify them and all appropriate Providers, in writing, of the first level 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 their decision within thirty (30) calendar days of the Plan Participant's request, unless the Claims Administrator mutually agrees that an extension of the time is warranted.

SECOND LEVEL OF STANDARD ADMINISTRATIVE APPEAL

If the Claims Administrator does not reverse the decision, the Plan Participant may further appeal the denial of Benefits to the Plan Administrator. A Plan Participant who is not satisfied with the decision may initiate a voluntary second level of Appeal. Requests submitted after sixty (60) calendar days of the denial will not be considered. Send a written request for further review and any additional information to:

Appeals Coordinator
Attention: Director of Human Resources
City of Baton Rouge/East Baton Rouge Parish
1755 Florida Street
Baton Rouge, LA 70802

The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

MEDICAL NECESSITY APPEALS

If the Plan Participant is not satisfied with the Claim Administrator's denial of services, the Plan Participant, their authorized representative, including 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 Benefit determination. Appeals should be submitted in writing to

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

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 Appeals of Medical Necessity denials 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 Necessity 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.

INVESTIGATIONAL APPEALS

If the Plan Participant is not satisfied with the denial of services, the Plan Participant, their authorized representative, including 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 Benefit determination. Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

Requests submitted to the Claims Administrator after one hundred eighty (180) days of the denial will not be considered.

If the initial denial is overturned on the Plan Participant's Investigational Appeal, the Claims Administrator will process the Claim and will notify the 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 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.

An Investigational denial is one which is based on: (a) if the item or service is subject to FDA approval, it must be so approved; and, (b) if the item is not subject to FDA approval, use of the item or service must be supported by medical or scientific evidence.

EXTERNAL APPEAL

If the Plan Participant still disagrees with the determination on their Claim, the Plan Participant or their authorized representative may request an external Appeal conducted by a non-affiliated Independent Review Organization (IRO). The Plan Participant must send their written request for an external Appeal, within one hundred twenty (120) days of receipt of the internal Appeal decision, to:

Appeals Coordinator
Attention: Director of Human Resources
City of Baton Rouge/East Baton Rouge Parish

Requests submitted to the Group after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered.

The Claims Administrator will provide all pertinent information necessary to conduct the Appeal. The IRO decision will be considered a final and binding decision on both the Plan Participant and the Claims Administrator. The external review 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.

EXPEDITED APPEALS

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 Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the covered person may experience pain that cannot be adequately controlled while awaiting a standard internal 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 covered person 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 covered person; the covered person's authorized representative, or the Provider acting on behalf of the covered person. Requests for an Expedited Internal Appeal may be oral or written and should be made to:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal - Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045
1-800-599-2583 or 1-225-291-5370

In any case where the Expedited internal Appeal process does not resolve a difference of opinion between the Claims Administrator and the covered person or the Provider acting on behalf of the covered person, the Appeal may be elevated to an Expedited External Appeal.

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 covered persons 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 decision is available if the Plan Participant's life, health or ability to regain maximum function is in serious jeopardy; 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. All pertinent information for Expedited External Appeal requests will be provided so the review may be completed within seventy-two (72) hours of receipt.

BINDING NATURE OF EXTERNAL APPEAL DECISIONS

The process of seeking Medical Necessity and Investigational Appeals is set forth above. All external review decisions are binding on the Plan and the covered person for purposes of determining coverage under a health Benefit Plan that involves a determination of Medical Necessity or whether a medical service is Investigational.

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 or Investigational.

ARTICLE XXII. HOW TO OBTAIN CARE WHILE TRAVELING, MAKE PLANCHANGES AND FILE 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 required, the Change of Status Card has the health questionnaire on the reverse side. If the Plan Participant needs to submit documentation to the Claims Administrator, the Plan Participant may forward it to Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA70898-9029, 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 Members 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 Change of Status Card 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 Change of Status Card 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 Change of Status Card 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 Plan Participant may also be asked to complete the health questions for these family members. The Schedule of Eligibility explains when coverage becomes effective for new family members. The Plan Participant must contact City-Parish Human Resources Payroll and Benefits Division 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 Network Providers or 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 date of service (Admission to a Hospital or other Provider) or date of treatment is correct

7. the Provider includes a diagnosis and procedure code for each service/treatment rendered

8. 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 or an enrolled family member is being admitted to a Preferred Network Provider or Participating Provider, the Plan Participant should show his 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. Emergency Room or 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 emergencies or 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. Prescription Drug Claims

   Most Plan Participants with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Plan Participants who present his ID card to a Participating Pharmacist. However, if the Plan Participant must file a Claim to access his Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to the Claims Administrator, may require the signature of the dispensing pharmacist. The claim form should then be sent to the Claims Administrator or their Pharmacy Benefit Manager, whose telephone number can be found on the Plan Participant's ID card.

   Benefits will be paid to the Plan Participant based on the Allowable Charge for the Prescription Drug.

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

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 contract number, patient's name and date of service.

Blue Cross and Blue Shield of Louisiana,
5525 Reitz Avenue
Baton Rouge, LA 70898-9029

Remember, the Plan Participant must ALWAYS refer to the his contract number in all correspondence and recheck it against the contract number on his ID card to be sure it is correct.

* Blue Cross and Blue Shield of Louisiana has local service offices located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

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.

ARTICLE XXIII. RESPONSIBILITIES OF PLAN ADMINISTRATION

A. Plan Administrator

The CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE Health Plan is the Benefit Plan of CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE 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, CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE 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 the employees and their Dependent(s), 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 to the extent they agree with 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.

GENERAL PLAN INFORMATION

Name of Plan:	City of Baton Rouge/East Baton Rouge ParishHealth Plan
Name and Address of Employer/ Plan Sponsor:	City of Baton Rouge/East Baton Rouge Parish P.O. Box 1471 Baton Rouge, La 70821
Employer Identification Number (EIN):	Group to provide
Plan Number (PN):	501
Type of Plan:	Group Major Medical Benefit Plan
Type of Administration:	The Plan's medical 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.
Name and Address of Plan Administrator:	City of Baton Rouge/East Baton Rouge Parish P.O. Box 1471 Baton Rouge, La 70821 225-389-3134
Agent for Service of Legal Process:	City of Baton Rouge/East Baton Rouge Parish 1755 Florida Street Baton Rouge, La 70802 225-389-3134
Plan Year Ends:	The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends on each 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 Plan indefinitely, the Plan Sponsor reserves the right to modify, amend, suspend, or terminate the Benefit Plan at any time.
Source of Contributions And Funding:	The cost of all coverage is shared by the Plan Participant and the Plan Sponsor. The Participant's contributions to the Benefit Plan are at a rate determined by the Plan Sponsor.
Department of Labor:	If you have any questions about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

CLAIMS ADMINISTRATOR:

Blue Cross and Blue Shield of Louisiana (BCBSLA)
5525 Reitz Avenue
Baton Rouge, LA 70809
(225) 295-3307

BCBSLA 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 BCBSLA. BCBSLA processes and pays Claims, then requests reimbursement from Plan. City of Baton Rouge/East Baton Rouge Parish, is ultimately responsible for providing plan benefits, and not BCBSLA.