
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**TERREBONNE PARISH SCHOOL BOARD
GROUP EMPLOYEE BENEFIT PLAN**

TABLE OF CONTENTS

INTRODUCTION.....	1
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS	3
SCHEDULE OF BENEFITS	13
MEDICAL BENEFITS	28
COST MANAGEMENT SERVICES	35
DEFINED TERMS	39
PLAN EXCLUSIONS	47
PRESCRIPTION DRUG BENEFITS	52
DENTAL BENEFITS	55
HOW TO SUBMIT A CLAIM.....	60
COORDINATION OF BENEFITS	64
THIRD PARTY RECOVERY PROVISION.....	67
COBRA CONTINUATION OPTIONS.....	72
HIPAA PRIVACY	80
HIPAA SECURITY	84
RESPONSIBILITIES FOR PLAN ADMINISTRATION	86
GENERAL PLAN INFORMATION.....	88

INTRODUCTION

This document is a description of Terrebonne Parish School Board Group Employee Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including, but not limited to, benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as, but not limited to, coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active and Retired Employees of the Employer as well as Surviving Dependents. Part-time employees are not eligible under the Plan.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) is an "Active, Full-Time Employee" if he or she is active at work at least 30 hours per week and/or assigned a position that is considered to be full-time by the Employer and on the regular payroll during any approved paid leave
- (2) is a Retired Employee of the Employer who has been covered for a minimum of 5 years under the medical and prescription benefits offered by the Employer immediately prior to the date of retirement and receives benefits from a participating state retirement system within 30 days from the date of separation from active status
- (3) is in a class eligible for coverage. Other eligible classes are:
 - a) Surviving Dependent
 - b) COBRA
- (4) and completes the employment Waiting Period of one month as an Active Employee. A "Waiting Period" is the time between the first day of employment and the first day of eligibility under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse;
- (2) any unmarried (never married) child(ren);
- (3) grandchild(ren) for whom the covered Employee has Legal Custody ordered by a court of law and the grandchild(ren) resides with the covered Employee.

Dependent children are eligible from birth to the age of 21 years. However, a Dependent child will continue to be eligible after age 21, provided the child is a full-time student at an accredited school, has never been married and under the limiting age of 24. When the child reaches either limiting age, coverage will end on the last day of the child's birthday month. If the child does not maintain full-time student status or graduates, coverage terminates independent of limiting age.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. A student will be considered full-time for the semester if the student is attending the semester/quarter as a registered full-time student as defined by the school.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship. A common law spouse is not eligible under the Plan, even in states where common law marriage is recognized.

The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption, and grandchildren for whom the covered Employee has legal custody and who reside with the covered Employee. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee.

If a covered Employee is the Legal Guardian of an unmarried (never married) child or children, these children may be enrolled in this Plan as covered Dependents.

- (4) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The following persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined herein; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country unless the board approves continuation while on active duty; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Terrebonne Parish School Board may pay the entire cost of Employee coverage under this Plan. Terrebonne Parish School Board may share the cost of Dependent coverage under this Plan with the covered Employees. An enrollment form for coverage will include a payroll deduction authorization. The authorization and enrollment forms must be filled out, signed and returned to the Insurance Department.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Until a Covered Person has been covered under the Plan for 12 consecutive months, or 18 months if a Late Enrollee, after a person's Enrollment Date, covered charges incurred under Medical Benefits for Pre-Existing Conditions are limited to a maximum benefit of \$1,000 for all such conditions combined. This time may be offset if the person has Creditable Coverage from his or her previous plan. This Pre-Existing condition limitation will no longer apply to a condition for which the Covered Person has not received any treatment or services for that condition for a period of six consecutive months.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 30 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee is not automatically enrolled in this Plan.

A newborn child is required to be enrolled and if not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments", there will be no payment from the Plan and the covered parent will be responsible for all costs. If the newborn child is not enrolled within 30 days of birth, any subsequent enrollment will be considered as a Late Enrollment

Charges for covered routine Physician care and nursery care will be applied toward the Plan of the newborn child if enrolled within 30 days of birth.

TIMELY OR LATE ENROLLMENT

DEPENDENTS OF RETIREES SHALL NOT BE ELIGIBLE FOR COVERAGE AS A LATE ENROLLEE

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under any Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins the first of the month after enrollment.

SPECIAL ENROLLMENT PERIODS

The effective date for anyone who enrolls under a Special Enrollment Period is the first of the month following 30 days from the end of a Special Enrollment Period. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is treated as a Waiting Period.

- (1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

 - (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA 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 towards the coverage were terminated.
 - (d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

- (2) **Dependent beneficiaries.** If:

 - (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
 - (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the marriage and after the date the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the first calendar month beginning after the date the Employee completes one calendar month service (Waiting Period) provided that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met. However, coverage for Dependents of a Retired Employee first becoming eligible after the date the Employee retires shall be effective on the first of the month following 30 days after the date the Dependent is first acquired, provided that an application for such coverage is made within 30 days of the date acquired. **DEPENDENT(S) OF A RETIREE SHALL NOT BE ELIGIBLE FOR COVERAGE AS LATE ENROLLEES.**

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan is terminated.
- (2) The date the covered Employee's Eligible Class is eliminated.
- (3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)

Continuation During Periods of Disability or Absence Without Pay. A person may remain eligible under COBRA if Active, full-time work ceases due to Total Disability or absence without pay.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period or Pre-Existing Conditions provision.

Employees on Military Leave.

May I continue participation while I am absent under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is a federal law, under which you may elect to continue coverage under the Plan for yourself and your Covered Dependents, where:

- They were covered persons in the Plan immediately prior to your leave of absence for uniformed service; and
- The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

- You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your Employer. This notice will not be required if

giving it is precluded by military necessity or is otherwise impossible or unreasonable;

- The cumulative length of this absence and all previous absences with your Employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and
- You comply with the notice requirements set forth in “When will coverage continued through USERRA terminate?”

The law requires your Employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?

The cost of continuing your coverage will be:

- For leaves of 30 days or less, the same as the contribution required from similarly situated employees;
- For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your Employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through USERRA terminate?

Continued coverage under this provision will terminate on the earlier of the following events:

- The date you fail to apply for, or return to, work for your Employer following completion of your leave. You must notify your Employer of your intent to return to employment within:
 - For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the Employer:
 - Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or
 - If reporting with such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.
 - For leaves of 30 to 180 days, by submitting an application for reemployment with your Employer:
 - Not later than 14 days after completing uniformed service; or

- If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.
- For leaves of more than 180 days, by submitting an application for reemployment with your Employer not later than 90 days after completing uniformed service.
- If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your Employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances; or
 - For elections before December 10, 2004, 18 months from the date your leave began.
 - For elections on or after December 10, 2004, 24 months from the date your leave began.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under COBRA.

How will my coverage be reinstated on return from *USERRA* leave?

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under *USERRA*?" and, if your absence was more than 30 days, you have furnished any available documents requested by your Employer to establish that you are entitled to the protections offered by *USERRA*. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under *USERRA*, contact your Employer.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.

- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)
- (4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) The date the Covered Employee retires if the Dependent was not a covered Dependent under the Plan for a minimum of five years prior to the date the covered employee separates from Active, full-time service.

Continuation for a Surviving Dependent of a Deceased Employee/Retiree. On the death of a covered Employee/Retiree, a covered Dependent may continue to be covered under this Plan. This continuation of coverage for the covered Dependent must be elected within 90 days following the death of the Employee/Retiree. Such Dependent is responsible for the required contributions.

Coverage for such surviving Dependent will end on the earliest of the following:

- (1) The end of the period for which any required contribution was received;
- (2) The date the Spouse becomes eligible for Medicare;
- (3) The date the Spouse is eligible to be covered by another group health plan;
- (4) The date the Spouse remarries;
- (5) The date a Dependent no longer meets the Plan's definition of an eligible Dependent; or
- (6) The date the Plan terminates.

This is an exception to provisions elsewhere in this Plan for an Eligible Dependent and Termination of Coverage.

SCHEDULE OF BENEFITS

Verification of Eligibility

Hospitals and Physicians: 1-888-215-9841

Participants: 1-888-472-4352

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

Facts that affect eligibility and benefit payments might be unknown to the Plan Administrator or third party administrator at the time verification must be given. Therefore, verification of eligibility or benefits is never a commitment or guarantee that the Plan will pay benefits.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

**Hospitalizations
MRI/CAT scans
Physical therapy
Cardiac workup
Outpatient surgical procedures (except procedures performed in the
Physician's office)
Spinal manipulations (precertification is not required for the first 4 visits in a
Calendar Year)
Colonoscopy
Esophagogastroduodenoscopy (EGD)
RAST/Allergy Testing
Amniocentesis
Thermography**

Please see the Cost Management section in this booklet for details.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. There may be distinctions for

benefits between Participating Providers based on contractual arrangements between the provider and the Plan. These special providers will be published and termed as “Exclusive Providers.” Because these Exclusive and Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an Exclusive Provider, that Covered Person will receive a higher payment from the Plan than when using a Participating Provider or a Non-participating Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, in-Network benefits will be provided for certain non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If the Covered Person is a Retiree and residing beyond a 50 mile radius of Terrebonne Parish.

If a Covered Person receives Physician or anesthesia services by a non-Network Provider at an in-Network facility.

Additional information about these options, as well as a list of Participating Providers, will be given to Plan Participants, at no cost, as needed.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is usually paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required. However, covered expenses incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year. Deductibles do not accrue toward the 100% maximum out-of-pocket payment. Copayments do not accrue toward the deductible.

A copayment is an amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

OPTION 1 MEDICAL BENEFITS

This portion of the Plan applies only to Covered Persons who have elected Option 1 benefits.

	PREFERRED PARTICIPATING PROVIDERS¹	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
¹ Effective May 15, 2005, eligible charges billed under the tax ID number for Physicians Surgical Specialty Hospital are payable at the Preferred Participating Providers benefit percentage level.			
MAXIMUM LIFETIME BENEFIT AMOUNT	\$1,000,000		
Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed three times under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating providers, including Out-of-Area providers.			
DEDUCTIBLES			
Separate deductible applies for Prescription drug expenses, see Prescription Drug Benefit.			
Per Covered Person, per Calendar Year	\$600	\$600	\$1,000
Per Family Unit, per Calendar Year	2 persons	2 persons	2 persons
The Calendar Year deductible is waived for the following Covered Charges: <ul style="list-style-type: none"> - Preadmission testing - Preventive Care 			
Per Hospital confinement in a Non-Network facility	N/A	N/A	\$1,000
COPAYMENTS			
Physician visits	\$20	\$30	N/A
Copayment applies to the office visit charge only.			
Emergency Room	See Covered Services below.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Covered Person	\$2,000	\$3,000	\$5,000
Per Family Unit	\$4,000	\$6,000	\$10,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.			
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. <ul style="list-style-type: none"> Deductible(s) Attention deficit/hyperactivity treatment charges Outpatient substance abuse treatment charges Outpatient mental disorder treatment charges Cost containment penalties Copayments 			

	PREFERRED PARTICIPATING PROVIDERS¹	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
¹ Effective May 15, 2005, eligible charges billed under the tax ID number for Physicians Surgical Specialty Hospital are payable at the Preferred Participating Providers benefit percentage level.			
COVERED SERVICES			
Supplementary Accident Charge Benefit			
Maximum benefit per accident.....first \$500, payable at 100% deductible waived			
Ambulance Service	85% after deductible	70% after deductible	70% after deductible*
Attention Deficit/Hyperactivity Disorder	50% after deductible \$2,500 Calendar Year maximum \$10,000 Lifetime maximum	50% after deductible \$2,500 Calendar Year maximum \$10,000 Lifetime maximum	50% after deductible* \$2,500 Calendar Year maximum \$10,000 Lifetime maximum
Eligible charge \$600 for initial visit and \$50 per visit thereafter.			
Durable Medical Equipment	85% after deductible	70% after deductible	50% after deductible*
Home Health Care	100% after deductible 50 visits Calendar Year maximum	100% after deductible 50 visits Calendar Year maximum	50% after deductible* 50 visits Calendar Year maximum
Hospice Care	85% after deductible 30 days outpatient Lifetime maximum	70% after deductible 30 days outpatient Lifetime maximum	50% after deductible* 30 days outpatient Lifetime maximum
Bereavement Counseling	85% after deductible	70% after deductible	50% after deductible*
Eligible charge \$100 per day for bereavement counseling.			
Hospital Services			
Room and Board	85% after deductible the semiprivate room rate	70% after deductible the semiprivate room rate	50% after deductible* the semiprivate room rate
Intensive Care Unit	85% after deductible 3 times semiprivate room rate	70% after deductible 3 times semiprivate room rate	50% after deductible* 3 times semiprivate room rate
Emergency Room	\$100 copayment then 85% after deductible	\$100 copayment then 70% after deductible	\$100 copayment then 50% after deductible*
Emergency room copayment waived if admitted to the Hospital directly from the emergency room.			
Jaw Joint/TMJ	85% after deductible	70% after deductible	50% after deductible*
Mental Disorders			
Inpatient	85% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum	70% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum	50% after deductible* 15 days Calendar Year maximum 30 days Lifetime maximum
Outpatient	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum

	PREFERRED PARTICIPATING PROVIDERS¹	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
¹ Effective May 15, 2005, eligible charges billed under the tax ID number for Physicians Surgical Specialty Hospital are payable at the Preferred Participating Providers benefit percentage level.			
Occupational Therapy	85% after deductible	70% after deductible	50% after deductible*
Organ Transplants	85% after deductible	70% after deductible	50% after deductible*
Outpatient Private Duty Nursing	85% after deductible \$10,000 or 15 shifts Calendar Year maximum, whichever occurs first	70% after deductible \$10,000 or 15 shifts Calendar Year maximum, whichever occurs first	50% after deductible* \$10,000 or 15 shifts Calendar Year maximum, whichever occurs first
Physical Therapy	85% after deductible	70% after deductible	50% after deductible*
Physician Services			
Inpatient visits	85% after deductible	70% after deductible	50% after deductible*
Office visits	100% after copayment for office visit charge only 85% after deductible for all other Covered Charges	100% after copayment for office visit charge only 70% after deductible for all other Covered Charges	50% after deductible*
Surgery	85% after deductible	70% after deductible	50% after deductible*
Allergy testing	85% after deductible	70% after deductible	50% after deductible*
Allergy serum and injections	85% after deductible	70% after deductible	50% after deductible*
Preadmission Testing	85%	70%	50%*
Pregnancy	100% after copayment for office visit charge for the first office visit 85% after deductible thereafter	100% after copayment for office visit charge for the first office visit 70% after deductible thereafter	50% after deductible*
Preventive Care			
Routine Well Adult Care Under age 40	100% after copayment for office visit charge only, 85% after deductible for other covered services	100% after copayment for office visit charge only, 70% after deductible for other covered services	not covered
Age 40 or over	100%	100%	
Includes: office visits including one each of the following services per Calendar Year: pap smear, mammogram (limited to a Participant age 40 or over), prostate screening/PSA (limited to a Participant over age 50), gynecological exam			
Routine Well Newborn Care	85% after deductible	70% after deductible	50% after deductible*

	PREFERRED PARTICIPATING PROVIDERS¹	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
¹ Effective May 15, 2005, eligible charges billed under the tax ID number for Physicians Surgical Specialty Hospital are payable at the Preferred Participating Providers benefit percentage level.			
Routine Well Child Care (limited to a covered Dependent child under age 16)	100%	100%	N/A
Includes: office visits, childhood immunizations (limited to a covered Dependent child under age 6).			
Prosthetics	85% after deductible	70% after deductible	50% after deductible*
Skilled Nursing Facility	85% after deductible one-half Hospital average semiprivate room and board rate within 14 days of a 3 day stay 100 visits days Calendar Year maximum	70% after deductible one-half Hospital average semiprivate room and board rate within 14 days of a 3 day stay 100 visits days Calendar Year maximum	50% after deductible* one-half Hospital average semiprivate room and board rate within 14 days of a 3 day stay 100 visits days Calendar Year maximum
Speech Therapy	85% after deductible	70% after deductible	50% after deductible*
Spinal Manipulation Chiropractic	85% after deductible	70% after deductible	50% after deductible*
Substance Abuse			
Inpatient	85% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum	70% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum	50% after deductible* 15 days Calendar Year maximum 30 days Lifetime maximum
Outpatient	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum
Inpatient/ Outpatient combined	\$10,000 Calendar Year maximum	\$10,000 Calendar Year maximum	\$10,000 Calendar Year maximum
Vision Therapy	85% after deductible	70% after deductible	50% after deductible*
X-ray/Lab Services	85% after deductible	70% after deductible	50% after deductible*
Inpatient or outpatient including services rendered in a Physician's office.			

*Benefit percentage increased to 80% for covered charges by a non-Network provider when incurred by a Covered Person who resides outside of the geographical service area served by the PPO network. The service area is a 50-mile radius of a Network provider.

SUPPLEMENTARY ACCIDENT CHARGE BENEFITS

This benefit applies when an accident charge is incurred for care and treatment of a Covered Person's Injury and:

- (1) the Injury is sustained while the person is covered for these benefits; and
- (2) the charge is for a service delivered within 90 days of the date of the accident; and
- (3) to the extent that the charge is not payable under any other benefits under the Plan (other than Medical Benefits).

BENEFIT PAYMENT

Benefits will be paid as described in the Schedule of Benefits.

ACCIDENT CHARGE

An accident charge is a Usual and Reasonable Charge incurred for the following:

- (1) Physician services.
- (2) Hospital care and treatment.
- (3) Diagnostic x-rays and lab tests.
- (4) Local professional ambulance service.
- (5) Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations.
- (6) Nursing service.
- (7) Anesthesia.
- (8) Covered Prescription Drugs.
- (9) Use of a Physician's office or clinic operating room.

OPTION 1 PRESCRIPTION DRUG BENEFITS
*****This portion of the Plan applies only to Covered Persons**
who have elected Option 1 benefits.***

Prescription Drug Deductible, per Calendar Year (waived for Generic drugs)

Per Covered Person	\$100
Per Family Unit	2

Pharmacy Option

Generic drugs

Copayment	\$5
Percentage payable	100%

Formulary Brand Name drugs

Copayment	\$20
Percentage payable	100%

Non-Formulary Brand Name drugs

Copayment	\$40
Percentage payable	100%

Mail Order Prescription Drug Option

Generic drugs

Copayment	\$5
Percentage payable	100%

Formulary Brand Name drugs

Copayment	\$20
Percentage payable	100%

Non-Formulary Brand Name drugs

Copayment	\$40
Percentage payable	100%

OPTION 1 DENTAL BENEFITS

*****This portion of the Plan applies only to Covered Persons who have elected Option 1 Dental benefits.*****

Calendar Year deductible, per person	\$50
per Family Unit	3

The deductible applies to these Classes of Service:
Class B Services - Basic

Dental Percentage Payable

Class A Services- Preventive.....	100%
Class B Services- Basic.....	80%

Note: For Late Enrollees, no benefits are payable for Class B Services in the first 6 months of the Covered Person's coverage under the Plan.

Maximum Benefit Amount

Per person per Calendar Year	\$1,000
---------------------------------------	---------

OPTION 2 MEDICAL BENEFITS

This portion of the Plan applies only to Covered Persons who have elected Option 2 benefits.

	PREFERRED PARTICIPATING PROVIDERS²	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
² Effective May 15, 2005, eligible charges billed under the tax ID number for Physicians Surgical Specialty Hospital are payable at the Preferred Participating Providers benefit percentage level.			
MAXIMUM LIFETIME BENEFIT AMOUNT	\$1,000,000		
Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed three times under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating providers, including Out-of-Area providers.			
HEALTH REIMBURSEMENT ARRANGEMENT	Please see brochure on Health Reimbursement Arrangement for details on this benefit.		
Per Covered Person, per Calendar Year	\$600		
Per Family Unit, per Calendar Year	\$900		
DEDUCTIBLES	Separate deductible applies for Prescription drug expenses, see Prescription Drug Benefit.		
Per Covered Person, per Calendar Year	\$1,000	\$1,500	\$3,000
Per Family Unit, per Calendar Year	\$1,500	\$2,000	\$4,500
The Calendar Year deductible is waived for the following Covered Charges: <ul style="list-style-type: none"> - Preadmission testing - Preventive Care 			
Per Hospital confinement in a Non-Network facility	N/A	N/A	\$1,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Covered Person	\$1,000	\$2,000	\$3,000
Per Family Unit	\$2,000	\$4,000	\$6,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.			
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Deductible(s) Attention deficit/hyperactivity treatment charges Outpatient substance abuse treatment charges Outpatient mental disorder treatment charges Cost containment penalties			

	PREFERRED PARTICIPATING PROVIDERS²	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
² Effective May 15, 2005, eligible charges billed under the tax ID number for Physicians Surgical Specialty Hospital are payable at the Preferred Participating Providers benefit percentage level.			
COVERED SERVICES			
Ambulance Service	90% after deductible	80% after deductible	70% after deductible
Attention Deficit/Hyperactivity Disorder	50% after deductible \$2,500 Calendar Year maximum \$10,000 Lifetime maximum	50% after deductible \$2,500 Calendar Year maximum \$10,000 Lifetime maximum	50% after deductible \$2,500 Calendar Year maximum \$10,000 Lifetime maximum
Eligible charge \$600 for initial visit and \$50 per visit thereafter.			
Durable Medical Equipment	90% after deductible	80% after deductible	70% after deductible
Home Health Care	100% after deductible 50 visits Calendar Year maximum	100% after deductible 50 visits Calendar Year maximum	70% after deductible 50 visits Calendar Year maximum
Hospice Care	90% after deductible 30 days outpatient Lifetime maximum	80% after deductible 30 days outpatient Lifetime maximum	70% after deductible 30 days outpatient Lifetime maximum
Bereavement Counseling	90% after deductible	80% after deductible	70% after deductible
Eligible charge \$100 per day for bereavement counseling.			
Hospital Services			
Room and Board	90% after deductible the semiprivate room rate	80% after deductible the semiprivate room rate	70% after deductible the semiprivate room rate
Intensive Care Unit	90% after deductible 3 times semiprivate room rate	80% after deductible 3 times semiprivate room rate	70% after deductible 3 times semiprivate room rate
Emergency Room	90% after deductible	80% after deductible	70% after deductible
Jaw Joint/TMJ	90% after deductible	80% after deductible	70% after deductible
Mental Disorders			
Inpatient	90% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum	80% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum	70% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum
Outpatient	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum
Occupational Therapy	90% after deductible	80% after deductible	70% after deductible
Organ Transplants	90% after deductible	80% after deductible	70% after deductible

	PREFERRED PARTICIPATING PROVIDERS²	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
² Effective May 15, 2005, eligible charges billed under the tax ID number for Physicians Surgical Specialty Hospital are payable at the Preferred Participating Providers benefit percentage level.			
Outpatient Private Duty Nursing	90% after deductible \$10,000 or 15 shifts Calendar Year maximum, whichever occurs first	80% after deductible \$10,000 or 15 shifts Calendar Year maximum, whichever occurs first	70% after deductible \$10,000 or 15 shifts Calendar Year maximum, whichever occurs first
Physical Therapy	90% after deductible	80% after deductible	70% after deductible
Physician Services			
Inpatient visits	90% after deductible	80% after deductible	70% after deductible
Office visits	90% after deductible	80% after deductible	70% after deductible
Surgery	90% after deductible	80% after deductible	70% after deductible
Allergy testing	90% after deductible	80% after deductible	70% after deductible
Allergy serum and injections	90% after deductible	80% after deductible	70% after deductible
Preadmission Testing	90%	80%	70%
Pregnancy	90% after deductible	80% after deductible	70% after deductible
Preventive Care			
Routine Well Adult Care Under age 40	90% after deductible	80% after deductible	70% after deductible
Age 40 and over	100%	100%	100%
Includes: office visits including one each of the following services per Calendar Year: pap smear, mammogram (limited to a Participant age 40 or over), prostate screening/PSA (limited to a Participant over age 50), gynecological exam, immunizations, cholesterol screening (including HDL), colorectal cancer screening, vision screening, hearing screening			
Routine Well Newborn Care	90% after deductible	80% after deductible	70% after deductible
Routine Well Child Care (limited to a covered Dependent child under age 16)	100%	100%	100%
Includes: office visits, childhood immunizations (limited to a covered Dependent child under age 6), vision screening, hearing screening.			
Prosthetics	90% after deductible	80% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible one-half Hospital average semiprivate room and board rate within 14 days of a 3 day stay 100 visits days Calendar Year maximum	80% after deductible one-half Hospital average semiprivate room and board rate within 14 days of a 3 day stay 100 visits days Calendar Year maximum	70% after deductible one-half Hospital average semiprivate room and board rate within 14 days of a 3 day stay 100 visits days Calendar Year maximum
Speech Therapy	90% after deductible	80% after deductible	70% after deductible

	PREFERRED PARTICIPATING PROVIDERS²	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
² Effective May 15, 2005, eligible charges billed under the tax ID number for Physicians Surgical Specialty Hospital are payable at the Preferred Participating Providers benefit percentage level.			
Spinal Manipulation Chiropractic	90% after deductible	80% after deductible	70% after deductible
Substance Abuse			
Inpatient	90% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum	80% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum	70% after deductible 15 days Calendar Year maximum 30 days Lifetime maximum
Outpatient	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum	50% after deductible 25 visits Calendar Year maximum 75 visits Lifetime maximum
Inpatient/ Outpatient combined	\$10,000 Calendar Year maximum	\$10,000 Calendar Year maximum	\$10,000 Calendar Year maximum
Vision Therapy	90% after deductible	80% after deductible	70% after deductible
X-ray/Lab Services	90% after deductible	80% after deductible	70% after deductible
Inpatient or outpatient including services rendered in a Physician's office.			

OPTION 2 PRESCRIPTION DRUG BENEFITS
*****This portion of the Plan applies only to Covered Persons**
who have elected Option 2 benefits.***

Prescription Drug Deductible, per Calendar Year (waived for Generic drugs)

Per Covered Person	\$100
Per Family Unit	2

Pharmacy Option

Generic drugs

Copayment	\$5
Percentage payable	100%

Formulary Brand Name drugs

Copayment	\$20
Percentage payable	100%

Non-Formulary Brand Name drugs

Copayment	\$40
Percentage payable	100%

Mail Order Prescription Drug Option

Generic drugs

Copayment	\$5
Percentage payable	100%

Formulary Brand Name drugs

Copayment	\$20
Percentage payable	100%

Non-Formulary Brand Name drugs

Copayment	\$40
Percentage payable	100%

OPTION 2 DENTAL BENEFITS

*****This portion of the Plan applies only to Covered Persons who have elected Option 2 Dental benefits.*****

Calendar Year deductible, per person	\$50
per Family Unit	\$3

The deductible applies to these Classes of Service:

- Class B Services - Basic
- Class C Services - Major

Dental Percentage Payable

Class A Services- Preventive.....	100%
Class B Services- Basic.....	80%
Class C Services- Major	50%
Class D Services- Orthodontia.....	50%

Note: For Late Enrollees, no benefits are payable for Class B Services in the first 6 months of the Covered Person's coverage under the Plan.

Note: For Late Enrollees, no benefits are payable for Class C Services in the first 12 months of the Covered Person's coverage under the Plan.

Note: For Late Enrollees, no benefits are payable for Class D Services in the first 24 months of the Covered Person's coverage under the Plan.

Maximum Benefit Amount

For other than Class D-Orthodontia:

Per person per Calendar Year	\$1,000
---------------------------------------	---------

For Class D-Orthodontia:

Lifetime maximum per person	\$1,500
-----------------------------------	---------

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

Deductible Three Month Carryover. Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year, provided that the deductible for the current plan year has not been met.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies, including charges for medications for use during the confinement, furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 90% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a) the patient is confined as a bed patient in the facility;
- (b) the confinement starts within 14 days of a Hospital confinement of at least 3 days; and
- (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement.

Covered charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.

- (a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

- (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
 - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure; and
 - (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the primary surgeon's allowance.
- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:
- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
 - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.
- (6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not

expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

(8) Other Medical Services and Supplies. These services and supplies not otherwise included in the items above are covered as follows:

- (a)** Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (b)** **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (c)** **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (d)** Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (e)** Initial **contact lenses** or glasses required following cataract surgery.
- (f)** Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
- (g)** Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome.**
- (h)** **Laboratory studies.**
- (i)** Treatment of **Mental Disorders and Substance Abuse.** Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- (j) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures or is certified by a doctor (MD, DO, DDS) in advance to the Plan Administrator that hospitalization is medically necessary:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Removal of impacted wisdom teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (k) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

- (l) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

- (m) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.
- (n) **Prescription Drugs** (as defined).
- (o) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

- (p) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts. Replacement of such devices is covered only if the attending physician certifies in writing that such replacement is medically necessary due to (1) a physical change in the condition of the patient's site of attachment, (2) the normal, physical growth of a dependent child, or (3) the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.
- (q) **Reconstructive Surgery.** Correction of abnormal congenital conditions, injuries sustained in an accident, loss of function by reshaping abnormal structures of the body caused by illness, injury, or developmental abnormalities, and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
 - (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.
- (r) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

- (s) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
- (t) **Sterilization** procedures.
- (u) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (v) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth. Charges for circumcision are not covered under the Plan.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

- (w) Charges for **vision therapy** (nonsurgical treatment to the eye muscles).
- (x) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 7 days in advance of services being rendered or within 48 hours after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
 - Hospitalizations
 - Cardiac workup
 - MRI/CAT scans
 - Colonoscopy
 - Esophagogastroduodenoscopy (EGD)
 - RAST/Allergy Testing
 - Amniocentesis
 - Thermography
 - Outpatient surgical procedures (except procedures performed in the Physician's office)
 - Physical therapy (precertification is not required for the first 4 visits in a Calendar Year)
 - Occupational therapy (precertification is not required for the first 4 visits in a Calendar Year)
 - Spinal manipulations(precertification is not required for the first 4 visits in a Calendar Year)
- (b) Retrospective review of the Medical Necessity when Precertification or Concurrent Review/Discharge Planning has not been secured;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The UR organization's staff cannot and does not verify benefits or eligibility. The UR organization's staff cannot and does not ensure that all plan requirements are met or will be met on the date services are rendered. The UR program's purpose is strictly the verification of Medical Necessity and the appropriateness of care. Certification or authorization of a Hospital stay, course of treatment or medical service is never a commitment or guarantee that the Plan will pay benefits.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 7 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** or on the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for Medical Necessity.

Preadmission certification is designed to assist with your hospital stay, not to determine which benefits will be payable. To find out which benefits are payable, please refer to the appropriate sections of this Plan.

If the Covered Person does not receive authorization as explained in this section, allowable expenses for outpatient services will be payable at a 50% benefit percentage and, for inpatient services, allowable expenses for Hospital room and board charges will be payable at a 50% benefit percentage.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Cataract surgery	Hysterectomy	Spinal surgery
Deviated septum (nose surgery)	Mastectomy surgery	Surgery to knee, shoulder, elbow or toe
Hemorrhoidectomy	Prostate surgery	Tympanotomy (inner ear)
Hernia surgery	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- (1) performed on an outpatient basis within seven days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered charges for this testing will be payable as shown in the Schedule of Benefits even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required. The deductible will also be waived for these tests.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan will consider care outside its normal benefit limitations if the use of an alternative treatment plan results in savings for the Plan and is endorsed by the participant. The objective of this service is to direct the patient toward the most appropriate care in a cost-effective environment. The Plan Administrator, attending Physician, patient and, in some circumstances, the patient's family must all agree to the alternate treatment plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is actively at work at least 30 hours per week or assigned a position that is considered to be full-time by the Employer.

Allowable Charge for in-network charges is the Preferred Provider Organization's contracted rate. For out-of-network charges, the Allowable Charge is the Usual and Reasonable amount.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Surgery. Surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Person is an Employee, Retiree, Dependent or Surviving Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to

generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Terrebonne Parish School Board.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its

safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy, or any surgical procedures for sterilization.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under the Employer's Plan.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically or Dentally Necessary (Medical Necessity) means care and treatment that is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight is contributing to or causing a serious medical disorder or illness as certified by the treating physician.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthotic Appliance is a rigid or semi-rigid device which restricts the motion of a body part.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a duly licensed Doctor of Medicine (M.D.), Osteopath, Podiatrist, Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), Doctor of Optometry, Chiropractor

and auxiliary personnel which can include clinical psychologists, board-certified social workers, licensed professional counselors, family nurse practitioners, physician assistants, certified registered nurse anesthetists, nurse midwives, physical and occupational therapists or any other licensed practitioner of the healing arts if he or she performs a covered service (1) within the scope of the license and (2) applicable state law requires such practitioner to be licensed.

Plan means Terrebonne Parish School Board Group Employee Benefit Plan, which is a benefits plan for certain employees of Terrebonne Parish School Board and is described in this document.

Plan Participant is any Employee, Retiree, Dependent or Surviving Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 30 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetic Device is an appliance which replaces all or part of a body organ or part.

Retired Employee is a former Active Employee of the Employer who has been covered for a minimum of 5 years under the medical and prescription benefits offered by the Employer immediately prior to the date of retirement and who receives benefits from a participating state retirement system within 30 days from the date of separation from active status.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health as certified by the treating physician.

Usual and Reasonable Charge and/or Reasonable and Customary is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will allow the actual charge billed if it is less than the Allowable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered.
- (2) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (3) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
- (4) **Conflicting Statements.** Charges which are incurred based on oral statements made by anyone involved in the administration of the Plan which are in conflict with the benefits described in this document.
- (5) **Contraceptives.** Charges for contraceptives or contraceptive devices are excluded. This does not include birth control pills covered under Prescription Drug benefits.
- (6) **Cosmetic Surgery.** Charges for Cosmetic Surgery are excluded.
- (7) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (8) **Durable Medical Equipment.** Replacement of durable medical equipment within five years unless approved by the Utilization Review company.
- (9) **Educational or vocational testing.** Services for educational or vocational testing, training, or bed and board while confined to an institution that is primarily a school or other institution for training.
- (10) **Electrical Power, Water Supply.** Charges for electrical power, water supply, sanitary waste disposal systems, saunas, hot tubs, or swimming pools or their installation, or any similar expense associated with a residence.

- (11) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.
- (12) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (13) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (14) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (15) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails unless for partial or complete removal of nail root (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (16) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (17) **Genetic Testing.** Charges for genetic testing or treatment.
- (18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (19) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (20) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.
- (21) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (22) **Hypnosis.** Charges for hypnosis (except when used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.
- (23) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

- (24) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (25) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization. Charges for surrogate mothers are not covered.
- (26) **Jail or prison confinement.** Charges for services received while confined in a prison, jail or other penal institution.
- (27) **Medicare Benefits.** Benefits which are paid by Medicare when Medicare is the primary payor. This limitation may apply to participants aged 65 or older, and is subject to federal legislation.
- (28) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (29) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (30) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (31) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (32) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan. Charges for diabetes management is covered.
- (33) **Nutritional Counseling.** Charges for nutritional counseling are excluded.
- (34) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.
- (35) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (36) **Orthotics.** Charges in connection with orthotics.

- (37) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds, and personal fitness equipment.
- (38) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or the existing device is unsafe and cannot be repaired or modified to achieve proper fit and function.
- (39) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (40) **Sales Tax or Interest.** Sales Tax or Interest for covered services or supplies.
- (41) **Scheduled visits.** Charges for failure to keep a scheduled visit or for completion of claim forms.
- (42) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.
- (43) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (44) **Sex Therapy, Marriage Counseling.** Charges in connection with sex therapy or marriage counseling.
- (45) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (46) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung illness such as emphysema or asthma.
- (47) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (48) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (49) **Vax-D Therapy.** Charges for Vax-D therapy.

- (50) Vitamins, Minerals, Food Supplements.** Charges for vitamins (except pre-natal vitamins), minerals, nutritional food supplements, or any over-the-counter items, whether or not prescribed by a physician, unless specifically covered herein.
- (51) War.** Any loss that is due to a declared or undeclared act of war or participating in a riot or other act of civil disobedience.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan through Script Care, Ltd. to charge Covered Persons reduced fees for covered Prescription Drugs. Script Care, Ltd. is the administrator of the pharmacy drug plan.

Copayments

After the prescription drug deductible amount has been met, the copayment is applied to each covered pharmacy drug or mail order drug charge. These amounts are shown in the schedule of benefits. The copayment amount is not a covered charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply, provided however that a prescription for greater dispensed quantities may be available with Physician certifications, but in no case shall exceed a 90-day supply. Any one mail order prescription is limited to a 90-day supply.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. This amount is not a covered charge under this Plan or the medical plan.

Mail Order Drug Benefit Option

The mail order drug benefit is an option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, medications for hair growth or removal, or Retin-A for Covered Persons 26 and older.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Growth hormones.** Charges for drugs to enhance athletic performance.
- (9) **Immunization.** Immunization agents or biological sera.
- (10) **Impotence.** A charge for impotence medication.
- (11) **Infertility.** A charge for infertility medication.
- (12) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- (13) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (15) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (16) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs, excluding Worker's Compensation.

- (17) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (18) **Over the Counter Medications.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or diabetic supplies.
- (19) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

DENTAL BENEFITS

The Dental Benefits of the Plan are made available to all Eligible Employees, Retirees and Surviving Dependents. Dental coverage is optional and the cost to participate is borne by the Participant. This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services: Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 1 per Covered Person each 6 months.

- (2) One bitewing x-ray series every 6 months.
- (3) One full mouth x-ray every 2 years.
- (4) One fluoride treatment for covered Dependent children under age 16 each Calendar Year.
- (5) Space maintainers for covered Dependent children under age 16 to replace primary teeth.
- (6) Emergency palliative treatment for pain.
- (7) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 16, once per tooth in any calendar year.

**Class B Services:
Basic Dental Procedures**

- (1) Dental x-rays not included in Class A.
- (2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- (3) Periodontics (gum treatments).
- (4) Endodontics (root canals).
- (5) Extractions. This service includes local anesthesia and routine post-operative care.
- (6) Recementing bridges, crowns or inlays.
- (7) Fillings, other than gold.
- (8) General anesthetics, upon demonstration of Medical Necessity.
- (9) Antibiotic drugs.

**Class C Services:
Major Dental Procedures**

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- (2) Installation of crowns.
- (3) Installing precision attachments for removable dentures.
- (4) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during 6 months following the installation.

- (5) Addition of clasp or rest to existing partial removable dentures.
- (6) Initial installation of fixed bridgework to replace one or more natural teeth.
- (7) Repair of crowns, bridgework and removable dentures.
- (8) Rebasing or relining of removable dentures.
- (9) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - (a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
 - (b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 6 months from the date the temporary denture was installed.
- (10) Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

**Class D Services:
Orthodontic Treatment and Appliances**

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be \$300 or more, a predetermination of benefits form may be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Gilsbar, Inc.
P.O. Box 2947
Covington, Louisiana 70434
985-892-3520

The Benefit Services Manager will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Broken appointments.** Charges for broken or missed dental appointments.
- (3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
- (5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (6) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- (7) **No listing.** Services which are not included in the list of covered dental services.
- (8) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (9) **Personalization.** Personalization of dentures.

- (10) **Replacement.** Replacement of lost or stolen appliances.
- (11) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- (12) Dental services provided by a Dentist who is a member of the participant's immediate family, or on behalf of any employer, a mutual benefit association, labor union, Trustee or group.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form online from the Benefit Services Manager at www.gilsbar.com or by contacting your Insurance Department.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician or Dentist complete the provider's portion of the form or attach the Physician's or Dentist's form to the Claim form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the address on the ID card.

WHEN CLAIMS SHOULD BE FILED

Claims incurred in a Plan Year must be filed with the Benefit Services Manager no later than June 30th following the end of the Plan Year. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than the June 30th deadline may be declined or reduced unless:

- (1) it's not reasonably possible to submit the claim in that time; and
- (2) the Plan Administrator, or Benefit Services Manager acting on the instructions of the Plan Administrator, finds that there was a reasonable cause for the delay.

The Benefit Services Manager will determine if enough information has been submitted to enable proper consideration of the claim. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW PROCEDURE

- (1) In cases where a claim for benefits payment is denied in whole or in part, whether the opinion was based on medical necessity or not, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:
 - (a) Request a review of any claim for benefits through the Benefit Services Manager. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any, and information sufficient for the Benefit Services Manager to identify the claim being appealed, such as claim number, explanation of benefits, date of service, and name of provider.
 - (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim, and include any additional material or information.

The request for review must be directed to the Benefit Services Manager within 60 days after the claim payment date or the date of the notification of the denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for medical review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based. This shall be the final appeal for any

claim for benefits denied in whole or in part, when the opinion was NOT based on medical necessity.

- (2)** In cases where the claim for benefits payment is denied upon appeal, and the opinion was based on medical necessity, the Plan Participant may request a second level appeal of the denial. This appeal provision will allow the Plan Participant to:
- (a)** Request through the Benefit Services Manager a second review of any claim for benefits where the opinion was based on medical necessity. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any, and information sufficient for the Benefit Services Manager to identify the claim being appealed, such as claim number, explanation of benefits, date of service, and name of provider.
 - (b)** File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim, and include any additional material or information including all facts and theories supporting the claim for benefits.

The request for review must be directed to the Benefit Services Manager within 60 days after the date of the notification of the appeal denial.

A review of the denial will be made by the Utilization Review Organization and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for medical review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

- (3)** In cases where the claim for benefits payment is again denied upon appeal, and the opinion was based on medical necessity, the Plan Participant may request a third, and final, appeal of the denial. This appeal provision will allow the Plan Participant to:
- (a)** Request directly to the Plan Administrator a third review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any, and information sufficient for the Plan Administrator to identify the claim being appealed, such as claim number, explanation of benefits, date of service, and name of provider.
 - (b)** File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim, and include any additional material or information.

The request for review must be directed to the Plan Administrator within 60 days after the date of the notification of the denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. No suit concerning the claim may be commenced until the appeal process has been completed and the written decision on the appeal is received by the Participant, or the Plan Administrator has not given a timely response to the appeal. The Participant has one year from that time to file suit. Suit may not be brought after the one-year period has passed.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Group practice and other group prepayment plans.
- (3) Federal government plans or programs. This includes Medicare.
- (4) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (5) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be no greater than a Preferred Provider's contracted rate for in-network charges or the Usual and Reasonable Charge for out-of-network providers and at least part of it must be covered by one or more of the Plans.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1)** This Plan is a secondary plan which determines benefits after the other plan unless the other plan has a coordination provision and the rules of both plans require this Plan to determine benefits before any other plan.
- (2)** Plans with a coordination provision will pay their benefits up to the Allowable Charge:

 - (a)** The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b)** The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c)** The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d)** When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

 - (i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e)** When a child's parents are divorced or legally separated, these rules will apply:

 - (i)** This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii)** This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

- (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
- (iv) If the specific terms of the court decree state that the parents shall 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 shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
- (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

Payment Condition

- (1) The Plan may elect, but is not required, to conditionally advance payment or extend credit of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of covered persons and their dependants ("Covered Person") where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision or other insurance policies or funds ("Coverage") is available.
- (2) Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the Plan's payment of medical benefits, to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the Plan or its assignee. By accepting benefits under the Plan, the Covered Person recognizes this property right or equitable interest of the Plan in any cause of action the Covered Person may have or the proceeds thereof.
- (3) In the event a Covered Person settles, recovers or is reimbursed by any third party or Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid as a result of said injury or condition. The Covered Person acknowledges that the Plan has the first priority right of recovery and a first lien to the extent of benefits provided by the Plan and shall be paid before any other claims for the Covered Person as the result of the illness or injury. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

Subrogation

- (1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to, and hereby does, subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any Coverage for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized and to reimburse the Plan for any such benefits paid when recovery is made.
- (2) If the Covered Person decides to pursue a claim against a third party or any Coverage available to him/her as a result of the said injury or condition, the Covered Person agrees to include the Plan's subrogation claim in that action and if there is a failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Covered Person decides not to pursue a claim against any third parties or Coverage the Covered Person authorizes the

Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the plan in the prosecution of any such claims.

- (3) The Plan may in its own name or in the name of the Covered Person or their personal representative commence a proceeding or pursue a claim against such other third person for the recovery of all damages in the full extent of the value of any such benefits or services furnished or payments advanced or credit extended by the Plan.
- (4) If the Covered Person fails to make a claim against or pursue damages against:
 - (a) the responsible party, its insurer, or any other source on behalf of that party;
 - (b) any first party insurance through medical payment coverage or personal injury protection;
 - (c) the Covered Person's uninsured or underinsured motorist coverage;
 - (d) any policy or contract of insurance from any insurance company or guarantor of a third party;
 - (e) worker's compensation or other liability insurance company or
 - (f) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and no-fault or school insurance coverages;

then the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person, or his or her guardian or the estate of a Covered Person, assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

Right of Reimbursement

- (1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, or other deductions, without regard to whether the Covered Person is fully compensated by his/her net recovery from all sources. The obligation exists whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. The obligation exists regardless of how classified or characterized and to reimburse the Plan for any such benefits paid when recovery is made. Said right and/or lien may be filed with any person or organization responsible, or potentially responsible, to the Covered Person for indemnification, the Covered Person's attorney, or the Court. If the Covered Person's net recovery is less than the benefits paid, then the Plan is entitled to be paid all of the net recovery achieved.

- (2) The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any Coverage. The Covered Person agrees to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Covered Person.
- (3) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
- (4) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

- (1) If at the time of injury, sickness, disease or disability there is available, or potentially available based on information known or provided to the Plan, to the Covered Person any other Coverage, including but not limited to judgment at law or settlements, the benefits under this Plan shall apply only as excess insurance over such other sources of indemnification. The Plan's benefits shall be excess to:
 - (a) the responsible party, its insurer, or any other source on behalf of that party;
 - (b) any first party insurance through medical payment coverage or personal injury protection;
 - (c) the Covered Person's uninsured or underinsured motorist coverage;
 - (d) any policy or contract of insurance from any insurance company or guarantor of a third party;
 - (e) worker's compensation or other liability insurance company or
 - (f) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and no-fault or school insurance coverages.

Obligations

- (1) It is the Covered Person's obligation to:
 - (a) to cooperate with the Plan or its agents in defining, verifying and protecting its rights of subrogation and reimbursement;
 - (b) to provide the Plan with pertinent information regarding the injury or sickness, including various forms of documentation, accident reports, settlement reports and any other requested additional information;

- (c) to take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - (d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - (e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received and
 - (f) to not settle, without the prior consent of the Plan, any claim that the Covered Person may have against any legally responsible party or insurance carrier; and
 - (g) to refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Covered Person for the injury or condition without obtaining the Plan's written approval.
- (2) Failure to comply with any of these requirements by the Covered Person, his or her attorney, or guardian may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld to satisfy the Covered Person's obligation. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursed received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

Minor Status

- (1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian, as the case may be, shall take and cooperate in any and all action requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.
- (2) If the minor's parents or court-appointed guardian fail or refuse to take such action, the Plan shall have no obligation to advance payment or extend credit of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

- (1) The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation/reimbursement rights. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice.

Severability

- (1) In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

COBRA CONTINUATION OPTIONS

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your dependents fail to make timely payment of premiums. You should check with your employer to see if COBRA applies to you and your dependents.

What is COBRA Continuation Coverage?

“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer’s plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;
2. The parent-Covered Employee's hours of employment are reduced;
3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Terrebonne Parish School Board, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail, hand delivery, or by facsimile to Plan Administrator:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration (“SSA”) to be disabled at some time before the 60th day of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Terrebonne Parish School Board
Plan Administrator
201 Stadium Drive
Houma, Louisiana 70361
985-876-7400

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;
2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the Covered

Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;

6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age, lost student status, married or other);
7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline; however, you must submit a copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the date you have provided the notice. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until you have provided a copy of the decree of divorce or legal separation or the SSA's determination.

Please note, if the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their

spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee may be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. An extra fee may be charged for this extended COBRA Continuation Coverage.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules). However, a Qualified Beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered) within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA

Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

Terrebonne Parish School Board
Plan Administrator
201 Stadium Drive
Houma, Louisiana 70361
985-876-7400

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

HIPAA PRIVACY

This section is intended to bring the Employer's Plan into compliance with the requirements of § 164.50(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.50(f) is referred to as the "504 provisions") by establishing the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information.

(1) Plan's Designation of Persons/Entities to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Employer to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from Plan Sponsor.)

(2) Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein.

The Plan Sponsor is the Employer (as listed in the General Plan Information section).

(3) The Plan's disclosure of Protected Health Information to the Plan sponsor – Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a business associate with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;

the Plan Documents have been amended to incorporate the Plan provisions set forth in this Section; and

the Plan Sponsor agrees to comply with the Plan provisions as modified by this Section.

(4) Permitted disclosure of individuals' Protected Health Information to the Plan Sponsor

The Plan (and any business associate acting on behalf of the Plan), or any business associate servicing the Plan will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this Section.

All disclosures of the Protected Health Information of the Plan's individuals by the Plan's business associate to the Plan Sponsor will comply with the restrictions and requirements set forth in this Section and in the "504 provisions".

The Plan (and any business associate acting on behalf of the Plan), may not, and may not permit a business associate, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504 provisions".

The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's business associate), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504 provisions", of which the Plan Sponsor becomes aware.

(5) Disclosure of Individuals' Protected Health Information – Disclosure by the Plan Sponsor

The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.

The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.

The Plan Sponsor will make and maintain an accounting so that it can make

available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan that the Plan Sponsor maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that made the return or destruction of the information infeasible.

The Plan Sponsor will ensure that the required adequate separation, described in paragraph 7 below, is established and maintained.

(6) Disclosures of Summary Health Information and Enrollment and Disenrollment Information

The Plan, or its business associate, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504 provisions", if the Plan Sponsor requests the summary health information for the purpose of:

Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

Modifying, amending, or terminating the Plan.

The Plan, or its business associate, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504 provisions".

(7) Required separation between the Plan and the Plan Sponsor

In accordance with the "504 provisions", this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a business associate servicing the Plan.

Risk Manger
Insurance Secretary/Adjustor
COE Insurance Clerk
Appropriate personnel of the Finance Dept.

This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Section.

The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA SECURITY

Effective April 20, 2005 (April 20, 2006 for small health plans as defined by 45 C.F.R. § 160.103), the following section will be added to the Plan. It is intended to bring the Terrebonne Parish School Board Group Employee Benefit Plan into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (the regulations are referred to herein as the “HIPAA Security Standards”) by establishing Plan Sponsor’s obligations with respect to the security of Electronic Protected Health Information.

Accordingly, the following is hereby included in the Plan effective on the applicable date shown above:

1. Definitions

Electronic Protected Health Information – The term “Electronic Protected Health Information” has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Security Incident – The term “Security Incident” has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

2. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- Plan Sponsor shall report to the Plan any Security Incident of which it becomes aware as described below:
 - Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

- Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis at renewal, or more frequently upon the Plan's request.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Terrebonne Parish School Board Group Employee Benefit Plan is the benefit plan of Terrebonne Parish School Board, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Terrebonne Parish School Board to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Terrebonne Parish School Board shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this 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 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.

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 which 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 Benefit Services Manager to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator compensation is determined by Terrebonne Parish School Board. All expenses for plan administration, including compensation for hired services, will be paid by the Plan.

BENEFIT SERVICES MANAGER IS NOT A FIDUCIARY. A Benefit Services Manager 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.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding may be derived solely from the funds of the Employer or from a combination of Employer and Participant funds.

For Dependent Coverage: Funding may be derived from the funds of the Employer and/or contributions made by the Participant.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Benefit Services Manager.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Benefit Services Manager. The funding for the benefits is derived from the funds of the Employer and contributions made by Participants. The Plan is not insured.

PLAN NAME

Terrebonne Parish School Board Group Employee Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 72-6001392

PLAN EFFECTIVE DATE: January 1, 2005

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Terrebonne Parish School Board
201 Stadium Drive
Houma, Louisiana 70361
985-876-7400

PLAN ADMINISTRATOR

Risk Manager
Terrebonne Parish School Board
201 Stadium Drive
Houma, Louisiana 70361
985-876-7400

BENEFIT SERVICES MANAGER

Gilsbar, Inc.
P.O. Box 2947
Covington, Louisiana 70434
985-892-3520

BY THIS AGREEMENT, Terrebonne Parish School Board Group Employee Benefit Plan is hereby adopted as shown effective as of the 1st day of January, 2005.

IN WITNESS WHEREOF, this instrument is executed for Terrebonne Parish School Board on or as of the day and year first below written.

By _____
Terrebonne Parish School Board

Date _____

Witness _____

Date _____

BY THIS AGREEMENT, Terrebonne Parish School Board Group Employee Benefit Plan is hereby adopted as shown effective as of the 1st day of January, 2005.

IN WITNESS WHEREOF, this instrument is executed for Terrebonne Parish School Board on or as of the day and year first below written.

By _____
Terrebonne Parish School Board

Date _____

Witness _____

Date _____