NGF LARGE GROUP

BLUE Connect

SAVINGS PLUS
HEALTH BENEFIT PLAN

HMO Louisiana

131HR 01431 0123R

HMO Louisiana

Thank you for choosing us!

It is my pleasure to welcome you to your new plan. If you are renewing your plan, welcome back! We are honored you chose the Cross and Shield for your health insurance needs. Please read this booklet for important information about your plan and how it works. If you have questions, we are here to help. Simply call the number on the ID card and We will do our best to assist you.

My best to you,

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

131HR 01431 0123R

Louisiana HMO Louisiana

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) ENROLLMENT NOTICE FOR ALL COVERED MEMBERS

If you have had or are going to have a mastectomy, you may be entitled to certain Benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed or reconstruction of both breasts if a bilateral mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to contralateral prophylactic mastectomy, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future;
- Prostheses; and
- Treatment of physical complications of all stages of the mastectomy, including lymphedema.

Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. You are eligible for these screenings if You:

- were previously diagnosed with breast cancer;
- completed treatment for breast cancer;
- underwent bilateral mastectomy; and
- were subsequently determined to be clear of cancer.

These Benefits will be provided in a manner determined in consultation with the attending Physician and the patient, and subject to the same Deductible Amount, Coinsurance, and Copayments applicable to other medical and surgical Benefits provided under this plan. Information on the plan's specific Deductible Amount, Coinsurance, or Copayment will be shown on the Schedule of Benefits.

If you have questions about this notice or about the coverage described herein, please contact our customer service department at the number listed on the back of the ID card.

BLUE CONNECT SAVINGS PLUS

GROUP HIGH DEDUCTIBLE HEALTH PLAN

NOTICES

HEALTHCARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTHCARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE NON-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR DEDUCTIBLE AMOUNTS, COINSURANCES AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT NETWORK AND NON-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT **WWW.BCBSLA.COM** OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON THE BACK OF THE ID CARD.

THE MEMBER'S SHARE OF THE PAYMENT FOR HEALTHCARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN THE MEMBER'S HEALTH PLAN AND THE MEMBER'S PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW THE MEMBER'S PROVIDER TO BILL THE MEMBER FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

We base Our payment of Benefits for the Member's Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom a Member receives Covered Services.

Note that federal law prohibits a Non-Network Provider from balance billing a Member for Non-Emergency Medical Services performed at a Network facility unless the Provider issued the required written notice to a Member and has obtained a Member's Informed Consent to provide such services.

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. The Company does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Breast reconstruction is covered for a Member who due to breast cancer obtains a partial mastectomy or a full unilateral or bilateral mastectomy as selected by the Member in consultation with the attending Physician(s). The services under this Benefit are subject to any Deductible Amount and Coinsurance.

Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. You are eligible for these screenings if You:

a. were previously diagnosed with breast cancer;
b. completed treatment for breast cancer;
c. underwent bilateral mastectomy; and
d. were subsequently determined to be clear of cancer.

These Covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with You and Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to any Deductible Amounts and Coinsurances.

Important information regarding this Plan will be sent to the mailing address provided for a Member on their Employee Enrollment / Change Form. **Members are responsible for keeping Us and the Group informed of any changes in their address of record.**

NOTICES

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

This Benefit Plan covers Prescription Drugs and uses either an open or closed Prescription Drug Formulary. Refer to Your Schedule of Benefits to see which Prescription Drug Formulary applies to You. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Benefit Plan. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost You less than drugs on higher tiers.

Information about Your formulary is available to You in several ways. Most Members receive information from Us by accessing the pharmacy section of Our website, **www.bcbsla.com/pharmacy**.

You may also contact Us at the telephone number on the ID card to ask whether a specific drug is included in Your formulary. If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your prescribing healthcare Provider will prescribe the drug for a particular medical condition or mental illness.

OPEN PRESCRIPTION DRUG FORMULARY

With an open formulary, the Company automatically includes new Prescription Drugs to Your coverage when drug manufacturers release these new drugs for sale.

You may file a written Appeal to Us if a Prescription Drug is not included in the formulary and Your prescribing healthcare Provider has determined that the drug is Medically Necessary for You. Instructions for filing an Appeal are included in this policy.

CLOSED PRESCRIPTION DRUG FORMULARY

A closed formulary means that selected Brand-Name Drugs, Generic Drugs, and Specialty Drugs when listed on the formulary are covered. Drugs that are not listed on the closed formulary, also called non-formulary drugs, are not covered.

For Prescription Drugs that are not included in Our Prescription Drug Formulary, there is a formulary exception process. This process allows You, Your designee or Your prescribing healthcare Provider to ask for a formulary exception from Us. This request must be based on Medical Necessity. If the request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary. If the request is not approved, You may file an internal or external formulary exception request to Us.

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

You have the right to continue the coverage of any Prescription Drug that was approved or covered by Us for a medical condition or mental illness, at the contracted Benefit level until the renewal of Your current insurance coverage regardless of whether the drug has been removed from Your formulary. Your prescribing healthcare Provider may prescribe a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug is covered under the health plan and is medically appropriate for You.

BLUE CONNECT SAVINGS PLUS
GROUP BENEFIT PLAN

TABLE OF CONTENTS

ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

HMO Louisiana, Inc. issues this Blue Connect Network Benefit Plan to the Group/Policyholder shown on the Schedule of Benefits. A copy of this Benefit Plan provided to Subscribers serves as the Subscriber's certificate of coverage. As of the Group's original Effective Date shown on the Schedule of Benefits, We agree to provide the Benefits specified herein for Subscribers of the Group and their enrolled Dependents. This Benefit Plan replaces any others previously issued to the Group/Policyholder, as of the amended Effective Date. This Benefit Plan describes Member Benefits, as well as Member rights and responsibilities under the Plan. We encourage You, the Member to read this Benefit Plan carefully.

You should call Us if You have questions about Your coverage, or any limits to the coverage available to You. Many of the sections of this Benefit Plan are related. You may not have all of the information You need by reading just one section. Please be aware that Your Physician does not have a copy of Your Benefit Plan, and is not responsible for knowing or communicating Your Benefits to You.

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

THIS COVERAGE AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (the Affordable Care Act) were signed into law in March, 2010. This coverage is compliant with and subject to the Affordable Care Act and covers all Essential Health Benefits required by law.

FACTS ABOUT THIS HIGH DEDUCTIBLE HEALTH PLAN

You have comprehensive medical and drug coverage, but have a restricted Network of Providers available to You – the Blue Connect Network (Network). You can get care from Providers who are not in Your Blue Connect Network, but Benefits will be paid at a lower level.

If You go to Providers in Your Blue Connect Network, You will pay the least for their care and get the most value from this Benefit Plan. This choice will determine the amount We pay and the amount You pay for Covered Services. Knowing the Network status of Your healthcare Provider is very important, since this is a narrow Network product. Costs to You vary significantly based on that.

This Benefit Plan is a high Deductible health plan, as long as the Deductible Amount meets the minimum required by federal law. This high Deductible coverage may be used in conjunction with a Health Savings Account (HSA), which a Member sets up through a financial institution. HSAs are portable, tax-advantaged savings accounts that act like a medical IRA. Unused money is rolled over from year to year, grows through interest and investments, and can be used to pay for a wide variety of health and wellness related products and services. The IRS has established eligibility rules for HSAs. Most adults who are covered by a high Deductible health plan, like this product, and who have no other no cost health coverage except for preventive care, may establish an HSA. Members that choose to take advantage of the Benefits of health savings accounts should learn about the laws affecting HSAs. They may wish to consult a qualified tax or financial advisor to ensure that they are eligible to establish an HSA, that they understand what other types of health coverage they may have without violating the HSA rules, what expenses may be paid from an HSA, and the many tax Benefits available to them if they properly comply with all IRS rules on health savings accounts.

Most Benefits are subject to the Member's payment of a Deductible Amount as stated in the Schedule of Benefits. After payment of applicable Deductible Amounts, Benefits are subject to two (2) Coinsurances (for example: 80/20, 60/40). The Member's choice of a Provider determines what Coinsurance applies to the service provided. We will pay the highest Coinsurance for Medically Necessary services when a Member obtains care from a Provider in the Blue Connect Network. We will pay the lower Coinsurances when a Member obtains Medically Necessary services from a Provider who is not in the Blue Connect Network.

OUR BLUE CONNECT PROVIDER NETWORK

Members choose which Providers will render their care. This choice will determine the amount We pay and the amount the Member pays for Covered Services.

HMO Louisiana, Inc. has put together a restricted Provider Network for this Benefit Plan, consisting of a select group of Physicians, Hospitals and other Allied Providers. We refer to these Providers as Blue Connect Network Providers, Network Providers or In-Network Providers. Oral Surgery Benefits are also available when rendered by Providers in the United Concordia Dental Advantage Plus Network or in Blue Cross and Blue Shield of Louisiana's dental Network.

We use the term Network Benefits to mean the highest level of Benefits payable under this Benefit Plan when the Member uses Providers in the Blue Connect Network. We use the term Non-Network Benefits to mean a lower level of Benefit if a Member chooses to go outside the Blue Connect Network for care. To receive Blue Connect Network Benefits, the Member should always verify that a Provider is a current Blue Connect Network Provider. Visit Our website at **www.bcbsla.com** or call customer service at the number on the ID card to verify that a Provider is a current Network Provider or to request a paper Provider directory. Our Blue Connect Network may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas.

A Provider may be contracted with Us when providing services at one location, and may be considered Out-of-Network when rendering services from another location. The Member should check the Provider directory to verify that the services are in the Blue Connect Network at the location where the Member is seeking care.

Additionally, Providers in the Blue Connect Network may be contracted to perform certain Covered Services but may not be contracted in the Blue Connect Network to perform other Covered Services. When a Blue Connect Network Provider performs services that the Blue Connect Network Provider is not contracted with Us to perform (such as certain High-Tech Imaging Services), Claims for those services will be adjudicated at the Non-Network Benefit level. The Member should make sure to check the Provider directory to verify that the services are Network when performed by the Provider or at the Provider's location.

We pay a lower level of Benefits when a Member uses a Provider outside the Blue Connect Network. Benefits may also be based on a lower Allowable Charge. This results in higher costs to the Member. A daily penalty may apply when Inpatient care is obtained from a Non-Network Hospital. A Non-Participating Hospital penalty may apply when Members receive care from a Non-Participating Hospital – a Hospital that is not in the Blue Connect Network, HMOLA Network or any other Blue Cross and Blue Shield plan. We recommend that You ask the Non-Network Physician or healthcare professional about their billed charges before You receive care.

- A Tier 1 Provider is a Blue Connect Network Provider. You get the best benefits and pay the least when you go to a Provider in the Blue Connect Network. Always get your services performed by a Tier 1 Provider if at all possible.

- A Tier 2 Provider is a Participating Provider -- not in the Blue Connect Network – that has signed a Provider agreement to participate in other networks of HMOLA, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan. If you cannot go to a Tier 1 Provider, you should do your best to go to a Tier 2 Provider. You will pay more than a Tier 1 Provider, but will receive significant cost protections that are available only when you see a Tier 1 or Tier 2 Provider.

- A Tier 3 Provider is a Non-Participating Provider or a Provider who is not in the Blue Connect Network and who has not signed a Provider agreement to participate in the HMOLA Network or any Blue Cross and Blue Shield plan. There are also Providers that are in other networks that have specifically chosen not to be in either Tier 1 or Tier 2 networks. These Providers may be indicated in the Blue Connect Network directory to help you select the lower cost providers. Tier 3 Providers will cost you the highest cost share and will not protect you from significant costs for their services. Avoid Tier 3 Providers if there is any way to get services from providers in the other tiers.

OBTAINING EMERGENCY AND NON-EMERGENCY CARE OUTSIDE LOUISIANA AND AROUND THE WORLD

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

In the United States:

Emergencies: To the extent required by applicable law, Members receive Network Benefits when covered Emergency Medical Services are provided by Providers that are not in Your Network.

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

Outside the United States:

Emergencies: To the extent required by applicable law, Members receive Network Benefits when covered Emergency Medical Services are provided by Providers that are not in Your Network.

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

How To Get Care Outside the Service Area:

1. In an Emergency, go directly to the nearest Hospital.
2. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest BlueCard® doctors and Hospitals (for care within the United States), or for information on Blue Cross Blue Shield Global® Core doctors and Hospitals (for care outside the United States). Provider information is also available at **www.bcbs.com**.
3. Use a BlueCard® Nationwide or a Blue Cross Blue Shield Global® Core Provider.
4. Present the ID card to the doctor or Hospital, who will verify coverage and file Claims for the Member.
5. The Member must obtain any required Authorizations from HMO Louisiana, Inc.

AUTHORIZATIONS

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

An Authorization is Our determination that it is Medically Necessary for the Member to receive the requested medical services. When We Authorize a service for Medical Necessity, We are not making a determination about the Member's choice of Provider or the level of Benefits that will apply to a resulting Claim.

Blue Connect Network Providers are required to obtain necessary Authorizations on behalf of the Member. When a Blue Connect Network Provider fails to obtain a required Authorization, We penalize the Blue Connect Network Provider, not the Member, as described on the Schedule of Benefits. The Member continues to be responsible only for the applicable Blue Connect Network Deductible Amount and/or Coinsurance shown on the Schedule of Benefits.

When We issue an Authorization but the Member receives the service from a Non-Network Provider (a Participating or Non-Participating Provider), Non-Network Benefits will apply, even when We have Authorized the services as

Medically Necessary. A Member must obtain care from a Provider in the Blue Connect Network to receive the highest level of Benefits available under this Benefit Plan.

If a Blue Connect Network Provider directs or refers a Member to another Provider, it is the Member's responsibility to make sure that the new Provider is in the Blue Connect Network, if the Member wants to receive Blue Connect Network Benefits.

No payment will be made for organ, tissue and bone marrow transplant Benefits or evaluations unless We Authorize these services. The services must be rendered by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or a transplant facility in Our HMOLA Provider Network, unless otherwise approved by Us in writing. To locate an approved transplant facility, contact Our customer service department at the number listed on the ID card.

HOW WE DETERMINE WHAT WE PAY FOR COVERED SERVICES

When the Member uses Blue Connect Network Providers (Tier 1)

Network Providers have signed contracts with Us to participate in the Blue Connect Provider Network. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services. This amount is the Blue Connect Network Provider's Allowable Charge and is used to determine the amount We pay for Medically Necessary Covered Services. Members who use Blue Connect Network Providers will receive Blue Connect Network Benefits and will pay the amounts shown in the Blue Connect Network column on the Schedule of Benefits for these Covered Services.

When the Member uses Participating Providers (Tier 2)

Participating Providers have not signed contracts for the Blue Connect Network, but have signed contracts with HMOLA Network, Blue Cross and Blue Shield of Louisiana or other Blue Cross and Blue Shield plans to participate in their Provider Networks. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services. This amount is the Participating Provider's Allowable Charge and is used to determine the amount that We pay for the Member's Medically Necessary Covered Services.

A Member receiving Covered Services from a Participating Provider will receive a lower level of payment than using a Blue Connect Network Provider, but the Member will not have to pay the difference between the Allowable Charge and the Provider's billed charge. The Member will pay the amounts shown in the Non-Network column on his Schedule of Benefits for these services.

The Member has the right to file an Appeal with Us for consideration of Network Benefits if the Member received Covered Services from a Participating Provider who was the only Provider available to deliver the Covered Service within a 75-mile radius of the Member's home. To file an Appeal, the Member must follow the Appeal procedures in this Benefit Plan.

When the Member uses Non-Participating Providers (Tier 3)

Non-Participating Providers do not have a contract with the Blue Connect Network, HMOLA Network, Blue Cross and Blue Shield of Louisiana, or any another Blue Cross and Blue Shield plan. These Providers are not in Our Networks. We have no fee arrangements with them. We establish an Allowable Charge for Covered Services provided by Non-Participating Providers. The Allowable Charge will be one of the following as determined by Us:

(1) An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;

(2) an amount We establish as the Allowable Charge; or

(3) the Provider's billed charge. You will receive a lower level of Benefit because You did not go to a Network Provider.

The Member may pay significant costs when he uses a Non-Participating Provider. This is because the amount that some Providers charge for a Covered Service may be higher than the established Allowable Charge. Also,

Network and Participating Providers waive the difference between their actual billed charge and their Allowable Charge, while Non-Participating Providers will not.

The Member has a right to file an Appeal with Us for consideration of Network Benefits if the Member received Covered Services from a Non-Participating Provider who was the only Provider available to deliver the Covered Service within a 75-mile radius of the Member's home. To file an Appeal, the Member must follow the Appeal procedures in this Benefit Plan.

Note that federal law prohibits a Non-Network Provider from balance billing a Member for Non-Emergency Medical Services performed at a Network facility unless the Provider issued the required written notice and has obtained a Member's Informed Consent to provide such services.

SAMPLE ILLUSTRATION OF MEMBER COSTS WHEN USING A NON-PARTICIPATING HOSPITAL

NOTE: The following example is for illustration purposes only and is not a true reflection of the Member's actual Deductible Amounts and Coinsurances. Please refer to the Schedule of Benefits to determine Your Benefits.

EXAMPLE: The Network Benefits are 80% - 20% Coinsurance with a Deductible Amount. The Non-Network Benefits are 60% - 40% Coinsurance with a Deductible Amount. Assume the Member goes to the Hospital, has previously met his Deductible Amount and has obtained the necessary Authorization prior to receiving a non-Emergency service. The Hospital bills $12,000 for the Covered Service. We negotiated an Allowable Charge of $2,500 with the Network Hospital to render this service. The Allowable Charge of the Participating Hospital is $3,000 to render this service. There is no negotiated rate with the Non-Participating Hospital. The Member is responsible for all amounts not paid by the Company, up to the Hospital's billed charge. This example illustrates the Member's costs at three different hospitals for the same service.

The Member receives Covered Services from:	**Network Hospital**	**Participating Hospital**	**Non-Participating Hospital**
Hospital Bill:	$12,000	$12,000	$12,000
Allowable Charge:	$2,500	$3,000	$2,500
We pay:	**$2,000** $2,500 Allowable Charge x 80% Coinsurance = $2,000	**$1,800** $3,000 Allowable Charge x 60% Coinsurance = $1,800	**$1,500** $2,500 Allowable Charge x 60% Coinsurance = $1,500
Member pays:	**$500** 20% Coinsurance x $2500 Allowable Charge = $500	**$1,200** 40% Coinsurance x $3,000 Allowable Charge = $1,200	**$1,000** 40% Coinsurance x $2,500 Allowable Charge = $1,000
Is Member billed up to the Hospital's billed charge?	NO	NO	YES - $9,500
TOTAL MEMBER PAYS:	**$500**	**$1,200**	**$10,500**

WHEN A MEMBER PURCHASES COVERED PRESCRIPTION DRUGS

Some pharmacies have contracted with Us or with Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are Participating Pharmacies. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is based on the amount We pay Our Pharmacy Benefit Manager. We use the amount we Pay Our Pharmacy Benefit Manager to base the Company's payment for a Member's covered Prescription Drugs and the amount that the Member must pay for covered Prescription Drugs.

When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our Pharmacy Benefit Manager or when a Member files a paper Claim with the Company or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that the Company pays Our Pharmacy Benefit Manager for covered Prescription Drugs. To obtain contact information for Participating Pharmacies, the Member should contact Our customer service department or Our Pharmacy Benefit Manager at the telephone number on the ID card.

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

The Company has contracted with an outside company to perform certain administrative services related to Mental Health and substance use disorder services for Our Members. For help with these Benefits, the Member should refer to the Schedule of Benefits, the ID card, or call Our customer service department.

MEMBER INCENTIVES AND VALUE-ADDED SERVICES

Sometimes We may offer Members coupons, discounts, and incentives to enroll in programs, such as pharmacy programs, disease management programs, and wellness programs and activities. We may offer Members discounts or financial incentives to use certain Providers for selected Covered Services. We may also offer Members the opportunity to enroll in health and non-health related programs, as Value-Added Services, to enhance the Member's experience with Us or his Providers. These incentives and Value-Added Services are not Benefits and do not alter or affect Member Benefits. They may be offered by Us, affiliated companies, and selected vendors. Members are always free to reject the opportunities for incentives and Value-Added Services. We reserve the right to add or remove any and all coupons, discounts, incentives, programs, and Value-Added Services at any time without notice to Members.

HEALTH MANAGEMENT AND WELLNESS TOOLS AND RESOURCES

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

CUSTOMER SERVICE E-MAIL ADDRESS

HMO Louisiana, Inc. has consolidated Our customer service e-mails into a single, easy-to-remember address: **help@bcbsla.com**. Customers who need to contact Us may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just go to **www.bcbsla.com** and click on *Need Help?* to access our Help Center which includes Our customer service contact information.

IDENTITY PROTECTION SERVICES

HMO Louisiana, Inc. is committed to identity protection for its covered Members. This includes protecting the safety and security of Members' information. To support the Company's efforts, HMO Louisiana, Inc. offers optional Identity Protection Services. If Identity Protection Services are elected, the services will include the following:

1. Credit monitoring which monitors activity that may affect credit;

2. Fraud detection which identifies potentially fraudulent use of identity or credit; and

3. Fraud resolution support that assists Members in addressing issues that arise in relation to credit monitoring and fraud detection.

Group Members are eligible to enroll in this service if their Employer Group has elected to participate in the service.

A Member ceases to be eligible for these services if health coverage is terminated during the Plan year. In this event, Identity Protection Services will terminate at the end of the Plan year.

Information about Identity Protection Services can be found at **www.bcbsla.com** or by calling the customer service telephone number on the ID card.

ARTICLE II. DEFINITIONS

Accidental Injury – A condition which is a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, injuries caused by the act of chewing do not constitute an injury caused by external force. If Benefits are available for the treatment of a particular injury, Benefits will be provided for an injury that results from an act of domestic violence or a medical condition.

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

Adverse Benefit Determination – Means denial or partial denial of a Benefit based on:

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

B. the Member's eligibility for coverage under the Benefit Plan;

C. any prospective or retrospective review determination;

D. a Rescission; or

E. a decision involving items and services within the scope of the surprise billing and cost-sharing protection requirements of the No Surprises Act.

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

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

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

Allowable Charge –

A. For Network Providers – The lesser of the billed charge or the amount We establish or negotiate as the maximum amount allowed for services from these Providers covered under this Benefit Plan.

B. For Non-Network Providers – The lesser of:

    1. An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays or what Medicare allows for the service;

    2. an amount We establish as the Allowable Charge; or

    3. the Provider's billed charge.

Alternative Benefits – Benefits for services not routinely covered under this Benefit Plan, but which the Company may agree to provide by agreement through Case Management when it is beneficial both to the Member and to Us.

Ambulance Service – Medically Necessary transportation by a specially designed emergency vehicle for transporting the sick and injured. The vehicle must be equipped as an emergency transport vehicle and staffed by

trained ambulance personnel as required by appropriate State and local laws governing an emergency transportation vehicle.

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

Appeal – A written request from a Member or a Member's authorized representative to change an Adverse Benefit Determination made by Us.

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

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

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

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

Beneficiary – A person designated by a Member, or by the terms of this Benefit Plan, who is or may become entitled to a Benefit under the plan.

Benefits – Coverage for healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies covered under this Benefit Plan. We base the payment for Benefits on the Allowable Charge for Covered Services.

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

Benefit Plan – This agreement, including the Application for Group Coverage, the Schedule of Benefits and amendments/endorsements to this agreement, if any, entitling the Subscriber and covered Dependents to specified health and Accidental Injury coverage.

Benefit Plan Date – The date upon which We issued this Benefit Plan to the Group.

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

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

Cardiac Rehabilitation – A structured program that provides coordinated, multi-faceted interventions including supervised exercise training, education, counseling and other secondary prevention interventions. It is designed to speed recovery from acute cardiovascular events such as myocardial infarction, myocardial revascularization, or hospitalization for heart failure and to improve functional and psychosocial capabilities.

Care Coordination – Organized, information-driven patient care activities, intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator Fee – A fixed amount paid by HMO Louisiana, Inc. to Providers periodically for Care Coordination under a Value-Based Program.

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

Cellular Immunotherapy – A treatment involving the administration of a patient's own (autologous) or donor (allogeneic) anti-tumor lymphocytes following a lymphodepleting preparative regimen.

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

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

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

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

Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a pair of percentages, a Company percentage that We pay, and a Member percentage that You pay. Once the Member has met any applicable Deductible Amount, the Member's percentage will be applied to the Allowable Charges for Covered Services to determine the Member's financial responsibility. Our percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Company – HMO Louisiana, Inc. (HMOLA)

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

Complication(s) – A medical condition, arising from an adverse event or consequence, which requires services, treatment or therapy and which is determined by Us, based on substantial medical literature and experience, to be a direct and consequential result of another medical condition, disease, service or treatment. Solely as an example, a pulmonary embolism after Surgery would be a Complication of the Surgery.

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

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

Congenital Anomaly – A condition existing at or from birth, which is a deviation from the common form or norm. Only deviations that impact bodily functions are covered. Examples of Congenital Anomalies that do not impact bodily function and are not covered include, but are not limited to: protruding ears, birthmarks, webbed fingers and toes, and asymmetrical breasts. Cleft Lip and Cleft Palate are covered Congenital Anomalies; other conditions relating to teeth or structures supporting the teeth are not covered. We will determine which conditions are covered as Congenital Anomalies.

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

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

Cosmetic Surgery – Any operative procedure, treatment, or service, or any portion of an operative procedure, treatment or service performed primarily to improve physical appearance. An operative procedure, treatment or service is not considered Cosmetic Surgery if it restores bodily function or corrects deformity to restore function of a part of the body that an Accidental Injury, disease, disorder, or covered Surgery has altered.

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

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

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to:

A. Providing personal care, homemaking, moving the patient;
B. Acting as companion or sitter;
C. Supervising medication that can usually be self-administered;
D. Treating or providing services that any person may be able to perform with minimal instruction; or
E. Providing long-term treatment for a condition in a patient who is not expected to improve or recover.

We determine which services are Custodial Care.

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

Deductible Amounts –

A. Individual Deductible Amount – The dollar amount, as shown on the Schedule of Benefits, of Allowable charges for Covered Services, which that a Member with Subscriber Only coverage must pay within a Benefit Period before the Plan starts paying Benefits.

B. Family Deductible Amount – The dollar amount, as shown on the Schedule of Benefits, of Allowable charges for Covered Services, which must be paid by a family within a Benefit Period before the Plan starts paying Benefits. If this Benefit Plan includes more than one (1) Member, the Individual Deductible Amount is not applicable. The Family Deductible Amount and the Per Member within a Family Amount applies. After the Family Deductible Amount is met, the Plan starts paying Benefits for all covered Members of the family for the remainder of the Benefit Period, whether each Member has met the Per Member within a Family Deductible Amount.

C. Per Member within a Family Deductible Amount – The dollar amount, as shown on the Schedule of Benefits, of Allowable charges for Network Covered Services, which may be paid by one (1) family member within a Benefit Period before this Benefit Plan starts paying Benefits. After a family member has met the Per Member within a Family Deductible Amount, the Plan starts paying Network Benefits for that family member, for the remainder of the Benefit Period. No family member may contribute more than the Per Member within a Family Deductible Amount towards satisfaction of the Family Deductible Amount.

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

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

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

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

Dependent – A person, other than the Subscriber, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

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

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

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

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

Eligible Employee – An Employee of the Group that has been determined by the Company as eligible to enroll in this plan.

Eligible Person – A person entitled to apply to be a Subscriber or a Dependent as specified in the Schedule of Eligibility.

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

Emergency – See Emergency Medical Condition.

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

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

Emergency Medical Services – The following when related to an Emergency Medical Condition, unless not required by applicable law:

A. When within the capability of a Hospital or independent freestanding emergency department, the following services and items:

    1. A medical screening examination, including ancillary services routinely available to the Emergency department to evaluate an Emergency Medical Condition.

    2. Further medical examination and such treatment as may be required to stabilize the medical condition, regardless of the department of the Hospital in which such
    further examination or treatment is furnished.

B. With respect to an Emergency Medical Condition and regardless of the department of the Hospital where furnished, additional services that are:

    1. Covered Services under the Benefit Plan;

    2. Furnished after the Member is stabilized; and

    3. Part of an Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Medical Services are furnished.

    If certain conditions set forth in applicable law are met, the additional services listed above are not deemed to be Emergency Medical Services and are not required to be covered as Emergency Medical Services.

Employee – A person who is a full-time Employee or Full-Time Equivalent as designated by the Employer.

Employer – Any person acting directly as an Employer, or indirectly in the interest of an Employer, in relation to an Employee Benefit Plan; and includes a Group or association of Employers acting for an Employer in such capacity.

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

Erectile Dysfunction – A condition in which the Member is unable to get or keep an erection firm enough to achieve penetration during sexual intercourse. Erectile Dysfunction can be a short-term or long-term condition.

Essential Health Benefits – Benefits required to be covered by this plan under the Patient Protection and Affordable Care Act, which include at least the following ten general categories: ambulatory patient services; Emergency Medical Services; hospitalization; maternity and newborn care; Mental Health and substance use disorder services, including behavioral health treatment; Prescription Drugs; Rehabilitative and Habilitative services and devices; laboratory services; Preventive or Wellness Care services and chronic disease management; pediatric services, including oral and vision care.

Expedited Appeal – A request for immediate internal review of an Adverse Benefit Determination, which involves any of the following situations:

A. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function.

B. In the opinion of the treating Physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

C. A decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare services for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

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

A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function.

B. A decision to not Authorize an Admission, availability of care, continued Hospital stay or healthcare service for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

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

External Appeal – A request for review by an Independent Review Organization, to change an initial Adverse Benefit Determination made by the Company or to change a final Adverse Benefit Determination rendered on Appeal. An External Appeal is available upon request by the Member or the Member's authorized representative for Adverse Benefit Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, Rescission or for Claims for which external review is provided under the No Surprises Act.

Full Time Equivalent (FTE) – An Employee who: (1) is employed on an average 30 or more hours per week; or (2) is working less than 30 hours per week on average, but is in the stability period defined under Internal Revenue Code §54.4980H-2(c) and regulations issued thereunder, and is documented and verified by the Employer to be in the stability period. A temporary Employee does not meet the eligibility requirements under this Benefit Plan, unless such temporary Employee is determined to be a Full Time Equivalent.

Gene Therapy – A treatment involving the administration of genetic material to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use.

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

Gestational Carrier – A woman, not covered on the Plan, who agrees to engage in a process by which she attempts to carry and give birth to a child born as the result of an in utero transfer of a human embryo to which she makes no genetic contribution.

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

Group – Any company, partnership, association, corporation or other legal entity which has made application for coverage herein and has agreed to comply with all the terms and requirements of this Benefit Plan. For purposes of this Benefit Plan, the Group is the policyholder.

Habilitative Care – Healthcare services and devices that help a patient keep, learn or improve skills and functioning for daily living. These services may include Physical Therapy, Occupational Therapy, Speech/Language Pathology

Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

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

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

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

Imaging Services –

A. Low-Tech Imaging – Imaging Services which include, but are not limited to, x-rays, machine tests, diagnostic imaging, and radiation therapy.

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

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

Independent Review Organization (IRO) – An entity, not affiliated with Us which conducts external reviews of Adverse Benefit Determinations, Rescission determinations and No Surprises Act-related decisions. The decision of the Independent Review Organization is binding on both the Members and Us, except to the extent that other remedies are unavailable under state or federal law.

Infertility – The inability of a couple to conceive after one (1) year of unprotected intercourse.

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

Informed Consent – A written document provided along with a written notice to a Member by a Non-Network Provider that must be executed by a Member in order for a Non-Network Provider to obtain the Member's consent to receive medical treatment and services from the Non-Network Provider without the protections provided by the No Surprises Act.

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

Intensive Outpatient Programs – Intensive Outpatient programs are defined as having the capacity for planned, structured, service provision of at least two (2) hours per day and three (3) days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured crisis intervention programs, psychiatric or psychosocial rehabilitation, and some day treatment. (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as

Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge).

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

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

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

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

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

    3. reference to federal regulations.

Life-Threatening Illness – A severe, serious, or acute condition for which death is probable.

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

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

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

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

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

Member – A Subscriber or an enrolled Dependent.

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

Negotiated Arrangement (Negotiated National Account Arrangement) – An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard® Program.

Network Benefits – Benefits for care received from a Blue Connect Network Provider. Network Benefits may also be referred to as In-Network.

Network Pharmacy – A pharmacy contracted with Us or Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for covered Prescription Drugs they dispense to Members. Network Pharmacies may also be referred to as Participating Pharmacies.

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

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

No Surprises Act (NSA) – A portion of the Consolidated Appropriations Act, 2021 (Public Law 116-260) enacted on December 27, 2020, that establishes patient rights and protections from surprise billing and limits cost-sharing under many of the circumstances in which surprise billing occurs most frequently.

Non-Network Benefits – Benefits for care received from Providers that are not in the Blue Connect Network. Non-Network Benefits may also be referred to as Out-of-Network.

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

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

Open Enrollment Period – A period of time, each year designated by the Group or by federal government, during which a Subscriber and the eligible Dependents may enroll for coverage under this Benefit Plan.

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

Out-of-Pocket Amounts –

A. Individual Out-of-Pocket Amount – The maximum amount, as shown on the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amount and Coinsurance), which must be paid by a Member with Subscriber Only coverage, within a Benefit Period. After the Individual Out-of-Pocket is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Covered Services.

B. Family Out-of-Pocket Amount – The maximum amount, as shown on the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amount and Coinsurance), which may be paid by a family within a Benefit Period. If the Benefit Plan covers more than one (1) Member, the Individual Out-of-Pocket Amount is not applicable. Only the Family Out-of-Pocket Amount is applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Covered Services, for all covered members of the family, for the remainder of the Benefit Period, whether each member has met the Per Member within a Family Out-of-Pocket Amount.

C. Per Member within a Family Out-of-Pocket Amount – The maximum dollar amount, as shown on the Schedule of Benefits, of non-reimbursable expenses for Network Covered Services, which may be paid by one (1) single family member within a Benefit Period. After the Per Member within a Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Network Covered Services, for that family member, for the remainder of the Benefit Period. No family member may contribute more than the Per Member within a Family Out-of-Pocket Amount towards satisfaction of the Family Out-of-Pocket Amount.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Over-Age Dependent – A Dependent Child (or Grandchild) who is age twenty-six (26) or older, reliant on the Subscriber for support, and is incapable of sustaining employment because of an intellectual or physical disability that began prior to age 26. Coverage of the Over-Age Dependent may continue after age 26 for the duration of incapacity if, prior to or within thirty-one (31) days of the Dependent Child reaching age 26, an application for continued coverage with current medical information from the Dependent Child's attending Physician is submitted to the Company. The Company may require additional or periodic medical documentation regarding the Dependent Child's intellectual or physical disability as often as it deems necessary, but not more frequently than once per year after the two-year period following the child's 26th birthday. The Company may terminate coverage of the Over-Age Dependent if the Company determines the Dependent Child is no longer reliant on the Subscriber for support or is no longer intellectually or physically disabled to the extent he is incapable of sustaining employment.

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

Pharmacy Benefit Manager (PBM) – A third-party administrator of Prescription Drug programs.

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

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

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

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

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

Prescription Drug Coinsurance – The sharing of Allowable Charges for Prescription Drugs. The sharing is expressed as a pair of percentages; a Company percentage that We pay and a Member percentage that You pay. Once the Member has met any applicable Prescription Drug Deductible Amount, the Member's percentage will be applied to the Allowable Charges for Prescription Drugs to determine the Member's financial responsibility. Our percentage will be applied to the Allowable Charges for Prescription Drugs to determine the Benefits provided. A different Prescription Drug Coinsurance may be required for the different drug tiers purchased at a retail pharmacy or through the mail.

Prescription Drugs – Medications, which includes Specialty Drugs, the sale or dispensing of which legally requires the order of a Physician or other healthcare professional and that carry the federally required product legend

stipulating that such drugs may not be dispensed without a prescription, and which are currently approved by the FDA for safety and effectiveness, subject to the Limitations and Exclusions Article.

Prescription Drug Formulary – A list of specific Prescription Drugs that are covered under this Benefit Plan.

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

Private Duty Nursing Services – Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is unrelated to the patient by blood, marriage or adoption. These services must be ordered by the attending Physician and require the technical skills of an RN or LPN. We determine which services are Private Duty Nursing Services. Private Duty Nursing Services that are determined by Us to be Custodial Care are not covered.

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

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

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

A. Blue Connect Provider – A Provider that has a signed contract with Us to participate in Our Blue Connect Provider Network. This Provider is also referred to as a Network Provider or In-Network Provider.

B. Participating Provider – A Provider that does not have a signed contract for the Blue Connect Network, but has a signed contract to participate in the Network of HMOLA, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan.

C. Non-Participating Provider – A Provider that does not have a signed contract for the Blue Connect Network, or a Network of HMOLA, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.

Provider Incentive – An additional amount of compensation paid to a healthcare Provider by a payer, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group or population of covered persons.

Pulmonary Rehabilitation – A comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors.

Rehabilitative Care – Healthcare services and devices that help a person keep, resume or improve skills and functioning for daily living that have been lost or impaired because a patient was sick, hurt or disabled. These services may include Physical Therapy, Occupational Therapy, Speech/Language Pathology Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Remote Patient Therapy – A mode of delivering healthcare services that involves the collection of and electronic transmission of biometric data that are analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health condition. Remote Patient Therapy services must be ordered by a

licensed Physician, physician assistant, advanced practice registered nurse, or other qualified healthcare Provider who has examined the patient and with whom the patient has an established, documented, and ongoing relationship.

Repatriation – The act of returning to the country of birth, citizenship or origin.

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

Residential Treatment Center – A twenty-four (24) hour, non-acute care treatment setting for the active treatment of specific impairments of Mental Health or substance use disorders.

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

Serious and Complex Condition – As used in the context of continuity of healthcare services, this term means:

A. For an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

B. For a chronic illness or condition, a condition that is:

    1. life-threatening, degenerative, potentially disabling, or congenital; and

    2. requires specialized medical care over a prolonged period of time.

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

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

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

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

D. Utilization review plans for all patients.

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

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

Special Enrollment Period – The thirty (30) day period of time during which a Subscriber and eligible Dependents may enroll or disenroll from coverage under this Benefit Plan outside of the Open Enrollment Period.

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

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

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

C. Unique patient compliance and safety monitoring requirements;

D. Unique requirements for handling, shipping and storage; and

E. Restricted access or limited distribution.

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

Speech/Language Pathology Therapy – The treatment used to manage speech/language, speech/language development, cognitive communication and swallowing disorders. The therapy must be used to improve or restore function.

Spouse – The Subscriber's legal Spouse.

Subscriber – An Employee, retiree, or elected official who has satisfied the specifications of this Benefit Plan's Schedule of Eligibility, has enrolled for coverage, and to whom We have issued a copy of this Benefit Plan.

Surgery –

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

B. The correction of fractures and dislocations.

C. Pregnancy Care, including vaginal deliveries and cesarean sections.

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

E. Other procedures as defined and approved by Us.

Telehealth Services – A mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, self-management of patients, and caregiver support at a distance from healthcare Providers approved by Us to render Telehealth Services. Telehealth Services give Providers the ability to render services when the Provider and patient are in separate locations.

A. Asynchronous Telehealth Services – the transmission of a patient's pre-recorded medical information from an originating site to the Provider at a distant site without the patient being present.

B. Synchronous Telehealth Services – the interaction between patient and Provider in different locations in real time, by means of two-way video and audio transmission, usually through an established patient portal.

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

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

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

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

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

Utilization Management – Evaluation of necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities.

Value-Added Service – Services available to the Group, with or without charge, that are provided outside the Benefits covered in this Benefit Plan. These services could include, but are not limited to development of training materials, COBRA administration, provision of analytic, enrollment, reporting, or other type of software, preparation of reports, compliance advice, etc. Value-Added Services are not considered Benefits under this plan or any other policy of insurance. The Group is never under any obligation to accept Value-Added Services, and the Company may cease offering and paying for Value-Added Services at any time.

Value-Based Program (VBP) – An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Waiting Period – See Eligibility Waiting Period.

Well Baby Care – Routine examinations of an infant under the age of twenty-four (24) months for whom no diagnosis is made.

ARTICLE III. SCHEDULE OF ELIGIBILITY

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

NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE.

A. Eligibility

1. Subscriber. To be eligible to enroll as a Subscriber, an individual must be:

    a. an Eligible Employee of the Group, who has satisfied any criteria designated by the Company to subscribe to this plan, has satisfied any Eligibility Waiting Period required by the Group, and who is working the number of hours required by Us to enroll in this coverage.

    b. a retiree who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Benefits; or

    c. an elected official who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Benefits.

2. Dependent. To be eligible to enroll as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Company that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Benefit Plan.

    a. Spouse

    b. CHILDREN: A child under age twenty-six (26) who is one of the following:

        (1) born of the Subscriber; or

        (2) legally placed for adoption with the Subscriber; or

        (3) legally adopted by the Subscriber; or

        (4) a child for whom the Subscriber or his Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Subscriber or his Spouse is a court appointed tutor/tutrix; or

        (5) a child supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or

        (6) a stepchild of the Subscriber; or

        (7) a grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or

        (8) the Subscriber's child or grandchild who is in the legal custody of and residing with the Subscriber, who is covered on the Plan before turning age twenty-six (26), and is able to remain covered on the Plan once turning age 26 because he meets the definition and requirements of an Over-Age Dependent.

B. Application for Coverage

When coverage is purchased, applications, changes and terminations must be made to the Company. The Company will determine and verify eligibility to enroll in this Benefit Plan and establish an Effective Date for coverage. Application for enrollment must be made to the Company during the Group's annual Open Enrollment Period. After the initial Open Enrollment Period, qualified persons generally may enroll in or change coverage only during subsequent Open Enrollment Periods or if an individual becomes eligible outside the annual Open Enrollment Period, he may apply for coverage beginning on the date he becomes eligible. A qualified individual may also enroll in coverage during a Special Enrollment Period available after certain events occur.

1. Every Eligible Person may enroll for coverage under this Benefit Plan and may include any Eligible Dependents.

2. The Group will submit all enrollment information to Us as a prerequisite to coverage under this Benefit Plan.

3. No person will be covered under this Benefit Plan unless the Company has accepted the enrollment form or enrollment information in a format acceptable to the Company, and the Company has issued the ID card or other written notice of acceptance. Payment of premiums will not effectuate coverage unless the ID card or other written acceptance has been issued. In the absence of such issuance, the Company's liability will be limited to refund of premiums paid.

4. This Group Benefit Plan and coverage under it will not be renewed or maintained unless the percentage of Eligible Persons specified by the Company is covered under the plan.

C. Available Classes of Coverage

The classes of coverage defined below are available subject to the selection of class or classes of coverage by the Group as shown on the Application for Group Coverage. The Group has the right to change the classes of coverage selected when needed by sending a request to change classes to Our underwriting department.

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

2. Subscriber and Spouse coverage means coverage for the Subscriber and his Spouse.

3. Subscriber and Family coverage means coverage for the Subscriber, his Spouse, and one or more Dependent children.

4. Subscriber and Child (or Children) coverage means coverage for the Subscriber and one or more Dependent children.

5. Subscriber and Dependent coverage means coverage for the Subscriber and one Dependent.

D. Effective Date

When the Company has accepted enrollment and required premiums for coverage have been paid, coverage will begin on the following applicable Effective Date, subject to any Eligibility Waiting Period:

1. If a person is an Eligible Person on this Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, this Group's Benefit Plan Date will be the Effective Date of coverage.

2. If a person becomes an Eligible Person after this Group's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s) on or before the eligibility date and the enrollment form is received by the Company within thirty (30) days of the eligibility date, the Effective Date of coverage will be the eligibility date.

3. If an Eligible Person's application for coverage for self or for self and any eligible Dependent(s) is not received by the Company within thirty (30) days of the eligibility date or Special Enrollment Period as described below, the request for enrollment will be denied. The Eligible Person shall be eligible to enroll for coverage during the next Open Enrollment Period.

4. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), and the enrollment form is received by the Company within one hundred and eighty (180) days of the date of birth, the Effective Date of coverage will be the date of birth.

E. Court Ordered Determination

If a court ordered determination is made to cover an eligible Dependent under an Employee's Benefit Plan, the Employee must enroll himself, if not already enrolled, and enroll the eligible Dependent by completing an enrollment form and submitting the enrollment form to Our home office within thirty (30) days after the court ordered determination. If timely enrolled, coverage for the eligible Dependent will be effective on the date of the court ordered determination.

F. Special Enrollment

1. Special Enrollment Due to Loss of Certain Other Coverage

   Special Enrollment Rights due to loss of certain other coverage are available only to current Employees or elected officials and their Dependents. These rights are not available to retirees.

   Individuals who lose other coverage because they did not pay their premiums or required contributions timely or lose other coverage for cause (such as filing fraudulent Claims or an intentional misrepresentation of a material fact in connection with the plan), are not Special Enrollees and have no special enrollment rights.

   An Eligible Person who is not enrolled under this Benefit Plan may be permitted to enroll as a Special Enrollee if each of the following conditions is met:

   a. The Eligible Person must be eligible for coverage under the terms of this Benefit Plan; and

   b. The Eligible Person must have declined enrollment under this Benefit Plan when offered;

   c. The Eligible Person lost coverage under a plan considered Creditable Coverage for HIPAA Portability purposes;

   d. The Eligible Person coverage described in c. above:

      (1) was under a COBRA continuation provision and the COBRA continuation period was exhausted due to one of the following:

         (a) the full COBRA continuation period was exhausted;

         (b) the Employer or other responsible entity failed to remit required premiums on a timely basis;

         (c) the individual whose coverage is through a Health Maintenance Organization (HMO), no longer lives, resides or works in the service area the HMO services, whether or not the choice of the individual in the service area, and there is no other COBRA coverage available;

         (d) the individual incurs a Claim that would meet or exceed a lifetime limit on all Benefits and there is no other COBRA continuation coverage available to the individual; or

      (2) was not under a COBRA continuation provision and lost other health coverage due to:

(a) loss of eligibility for coverage. Loss of eligibility for coverage includes but is not limited to the following:

(i) loss of eligibility as a result of legal separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the hours of employment;

(ii) in the case of coverage offered through a Health Maintenance Organization (HMO) in the individual market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual;

(iii) in the case of coverage offered through an HMO in the Group market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual, and no other health coverage is available to the individual; or

(iv) a plan no longer offers any Benefits to the class of similarly situated individuals.

(b) termination of Employer contributions to the other coverage.

A Special Enrollee under this section must request enrollment for coverage under this Benefit Plan within thirty (30) days after other coverage ends (or after the Employer stops contributing toward the other non-COBRA coverage). If such enrollment is received by a HMO Louisiana, Inc. office within thirty (30) days after loss of other coverage, coverage will become effective on the date other coverage is lost. If the enrollment is not received within thirty (30) days of the loss of other coverage, but is received within sixty (60) days of loss of other coverage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if HMO Louisiana, Inc. does not receive the request for enrollment form within sixty (60) days of the loss of other coverage.

2. Special Enrollment of a Dependent Child Due to Loss of Coverage Under the Children's Health Insurance Program or a Medicaid Program

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

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

3. Special Enrollment Due to Acquiring a Dependent

a. This Benefit Plan shall provide for a special enrollment period during which the Dependent of a participating Employee, retiree, or elected official may be enrolled on the plan. If not already participating, a current Employee or elected official may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period. (Retirees who are not currently participating do not have these special enrollment rights for adding Dependents and may not come on the plan for this reason.)

b. A person becomes a Dependent of the covered or eligible Employee, retiree or elected official through marriage, birth, adoption, or placement for adoption. In the case of the birth, adoption, or placement for adoption of a child, the Spouse of the Employee, retiree or elected official may be enrolled as a Dependent if he is otherwise eligible for coverage.

c. If the Group offers multiple health plan options, another option may be chosen by the current Employee, retiree or elected official for himself and Dependents when special enrollee status applies.

d. There is a thirty (30) day period of automatic coverage for Newly Born Infants (natural born or adopted), as described below. Any period of automatic coverage runs concurrently with the Special Enrollment Period for adding these infants to this Benefit Plan.

e. The Special Enrollment Period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied and any period of automatic coverage for Newly Born Infants will end.

f. In the case of a birth, adoption, or placement for adoption, a current Employee may enroll himself, his Spouse and/or the newborn/adopted child and other eligible dependent children. The enrollment must be requested by signing an enrollment form no later than thirty (30) days after the birth, adoption, or placement for adoption. If the enrollment form is received by an HMO Louisiana, Inc. office no later than thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth for a natural Newly Born Infant, and upon the date of adoption, or placement for adoption for an adopted Newly Born Infant. A Subscriber may enroll an unborn natural child prior to birth; however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth.

g. If the signed enrollment form is not received by Us within thirty (30) days of birth, adoption or placement for adoption, any automatic coverage period will end. If the signed enrollment form is not received by Us within thirty (30) days of birth, adoption or placement for adoption but is received within sixty (60) days of birth, adoption or placement for adoption, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. No coverage will be available if the enrollment form is not signed within thirty (30) days of the birth, adoption, or placement of adoption. Coverage will not be available if We do not receive the enrollment form within sixty (60) days of birth, adoption, or placement for adoption.

h. In the case of marriage, a current Employee may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested by signing an enrollment form within thirty (30) days of the marriage. Coverage will become effective on the date of marriage if the enrollment form is received by an HMO Louisiana, Inc. office within thirty (30) days of the marriage. If the enrollment form is not received by Us within thirty (30) days of marriage, but is received within sixty (60) days of marriage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment.

Coverage will not be available if the enrollment form is not signed within thirty (30) days of the marriage. Coverage will not be available if We do not receive the enrollment form within sixty (60) days of marriage.

4. Automatic Coverage Period for Newly Born Infants (Newborns)

a. If a child is born to a Subscriber holding Subscriber Only coverage or Subscriber and Spouse coverage, the following will apply:

(1) Such child will be covered automatically for thirty (30) days from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to his home, whichever is longer. This is the automatic coverage period. Automatic coverage for the child will be provided on the mother's policy, if any. If the mother has no policy, then automatic coverage will be provided on the father's policy, provided he has notified Us of the birth of the child. Coverage for the child will continue in effect thereafter, only upon Our receipt of a completed Employee Enrollment

Change Form prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the child are paid when billed.

(2) If the completed Employee Enrollment / Change Form is not received within this period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the child must be made at open enrollment or under a special enrollment provision.

b. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), the Effective Date for coverage for such child will be the date of birth. You must notify Us within one hundred and eighty (180) days of the birth to update Our records.

5. Automatic Coverage Period for Newly Born Adopted Infants

a. For Members holding Subscriber Only coverage or Subscriber and Spouse coverage:

If within thirty (30) days of the birth of a child, the child is either: legally placed into Subscriber's home for adoption following a voluntary act of surrender to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to a Subscriber, the following will apply:

(1) The child will be covered automatically for thirty (30) days from the date of legal placement into the Subscriber's home or from the custody order, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit, whichever is longer. The infant will not be covered from birth. Coverage for the infant will continue in effect thereafter, only upon Our receipt of a completed Employee Enrollment / Change Form prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the infant are paid when billed.

(2) If the completed Employee Enrollment / Change Form is not received within this period of automatic coverage, coverage for the infant will terminate upon the expiration of the period of automatic coverage. Any later request to add coverage for the child may be made at open enrollment or under a special enrollment provision.

b. For Members holding Subscriber and Family coverage or Subscriber and Child(ren) coverage:

If within thirty (30) days of the birth of a child, the Newly Born Infant is either: legally placed into the Subscriber's home for adoption following a voluntary act of surrender, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to a Subscriber holding coverage which includes Dependent children, the Effective Date of coverage of the adopted Newly Born Infant will be the date of placement into Subscriber's home or the date of the custody order. The child will not be effective from birth. You must notify Us within one hundred eighty (180) days of the date of placement in the home or of the custody order to update Our records.

6. In all special enrollee circumstances, an Employee, retiree or elected official must be enrolled in this Benefit Plan in order for his Dependent(s) to be enrolled.

ARTICLE IV. BENEFITS

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

A. Benefit Categories

1. If this Benefit Plan includes more than one (1) Member, the Individual Deductible Amount is not applicable. The Family Deductible Amount and the Per Member within a Family Deductible Amount applies.

2. If this Benefit Plan includes more than one (1) Member, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies.

3. Network and Non-Network Benefit categories may each carry separate Deductibles Amounts and Out-of-Pocket Amounts, as shown on the Schedule of Benefits. Amounts that apply to a Network Deductible Amount do not apply to a Non-Network Deductible Amount. Amounts that apply to a Non-Network Deductible do not apply to a Network Deductible Amount.

B. Deductible Amounts and Coinsurance

1. Subject to the Deductible Amount as shown on the Schedule of Benefits, the maximum limitations hereinafter provided and other terms and provisions of this Benefit Plan, the Company will provide Benefits in accordance with the Coinsurance shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Member during a Benefit Period.

   a. Individual Deductible Amount: The dollar amount, as shown on the Schedule of Benefits, of Allowable charges for Covered Services, which a Member with Subscriber Only coverage must pay within a Benefit Period before the Plan starts paying Benefits.

   b. Family Deductible Amount: The dollar amount, as shown on the Schedule of Benefits, of Allowable charges for Covered Services, which may be paid by a family within a Benefit Period before the Plan starts paying Benefits. After the Family Deductible Amount is met, the Plan starts paying Benefits for all covered members of the family, for the remainder of the Benefit Period, whether each member has met the Per Member within a Family Deductible Amount.

   c. Per Member within a Family Deductible Amount: The dollar amount, as shown on the Schedule of Benefits, of Allowable charges for Network Covered Services, which may be paid by one (1) family member within a Benefit Period before the Plan starts paying Benefits. After a family member has met the Per Member within a Family Deductible Amount, the Plan starts paying Network Benefits, for that family member, for the remainder of the Benefit Period.

      No family member may contribute more than the Per Member within a Family Deductible Amount towards satisfaction of the Family Deductible Amount.

      When a child is born to a Member having Subscriber only coverage, the child is granted 30 days of automatic coverage on the Benefit Plan from the date of birth and the Deductible Amount will increase from an Individual Deductible Amount to a Family Deductible Amount. The Claim for the delivery charges may be applied to the new Family Deductible Amount.

2. The Coinsurance is shown on the Schedule of Benefits for a Covered Service. The Member must first pay any applicable Deductible Amount before the Coinsurance. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in the Coinsurance shown in the Schedule of Benefits toward Allowable charges for Covered Services.

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

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

5. Under certain circumstances, if the Company pays a healthcare Provider amounts that are Your responsibility, such as Deductible Amount or Coinsurance, the Company may collect such amounts directly from You. You agree that Company has the right to collect such amounts from You.

C. Out-of-Pocket Amounts

1. Individual Out-of-Pocket Amount: The maximum amount, as shown on the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amount and Coinsurance), which may be paid by a Member with Subscriber Only coverage, within a Benefit Period. After the Individual Out-of-Pocket is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Covered Services, for the remainder of the Benefit Period.

2. Family Out-of-Pocket Amount: The maximum amount, as shown on the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amounts and Coinsurance), which may be paid by a family within a Benefit Period. If the Benefit Plan covers more than one (1) Member, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Covered Services, for all covered members of the family, for the remainder of the Benefit Period, whether each member has met the Per Member within a Family Out-of-Pocket Amount.

3. Per Member within a Family Out-of-Pocket Amount: The maximum dollar amount, as shown on the Schedule of Benefits, of non-reimbursable expenses for Network Covered Services, which may be paid by one (1) family member within a Benefit Period. After the Per Member within a Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Network Covered Services, for that family member, for the remainder of the Benefit Period.

   No family member may contribute more than the Per Member within a Family Out-of-Pocket Amount towards satisfaction of the Family Out-of-Pocket Amount.

4. The following accrue to the Out-of-Pocket Amount:

   a. Deductible Amount; and

   b. Coinsurance.

5. The following do not accrue to the Out-of-Pocket Amount:

   a. any charges in excess of the Allowable Charge;

   b. any penalties the Member or Provider must pay; and

   c. charges for non-Covered Services.

6. Amounts paid by Members for Covered Services provided by Participating and Non-Participating (collectively Non-Network) Providers will accrue to the Out-of-Pocket Amount for Network Providers when required by law.

D. Accumulator Transfers

Members' needs sometimes require that they transfer from one policy to another. Types of transfers include, but are not limited to, moving from one Employer's plan to another, from a Group policy to an individual policy, an individual policy to a Group policy, or a Blue Cross and Blue Shield of Louisiana policy to an HMO Louisiana, Inc. policy. The type of transfer being made determines whether the Member's accumulators are carried from the old policy to the new policy. Accumulators include, but are not limited to, Deductible Amounts, Out-of-pocket Amounts, and Benefit Period Maximums.

ARTICLE V. HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-emergency, Emergency, Pregnancy Care, Mental Health and substance use disorder Admissions) must be Authorized as outlined in Care Management Article and the Pregnancy Care and Newborn Care Benefits Article. In addition, at regular intervals during the Inpatient stay, the Company will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care. The Member must pay any Deductible Amount and any Coinsurance shown on the Schedule of Benefits.

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

The following services furnished to a Member by a Hospital are covered:

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Member requiring an intensive level of care.
3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us.
4. In a Residential Treatment Center for Members with Mental Health and substance use disorder Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

1. Use of operating, delivery, recovery and treatment rooms and equipment.
2. Drugs and medicines including take-home Prescription Drugs.
3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.
4. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital employee.
5. Medical and surgical supplies, casts, and splints.
6. Diagnostic Services rendered by a Hospital employee.
7. Physical Therapy provided by a Hospital employee.
8. Psychological testing when ordered by the attending Physician and performed by a Hospital employee.

C. Pre-Admission Testing

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

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

Benefits for the following medical and Surgical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. The Member must pay any applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.

A. Surgical Services

1. Surgery

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

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

2. Multiple Medical or Surgical Services - When Medically Necessary multiple services (concurrent, successive, or other multiple medical or surgical services) are performed at the same encounter, Benefits will be paid as follows:

   a. Primary Service

      (1) The primary or major service will be determined by Us.

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

   b. Secondary Service

      A secondary service is a service performed in addition to the primary service as determined by Us. The Allowable Charge for any secondary service will be based on a percentage of the Allowable Charge that would be applied had the secondary service been the primary service.

   c. Incidental Service

      (1) An incidental service is one carried out at the same time as a primary service as determined by Us.

      (2) Covered incidental services are not reimbursed separately. The Allowable Charge for the primary service includes coverage for any incidental service. If the primary service is not covered, any incidental service will not be covered.

   d. Unbundled Services

      (1) Unbundling occurs when two (2) or more service codes are used to describe a medical or surgical service performed when a single, more comprehensive service code exists that accurately describes the entire medical or surgical service performed. The unbundled services are considered included in the proper comprehensive service code as determined by Us.

      (2) The Allowable Charge of the comprehensive service code includes the charge for the unbundled services. We will provide Benefits according to the proper comprehensive service code, as determined by Us.

   e. Mutually Exclusive Services

      (1) Mutually exclusive services are two (2) or more services that usually are not performed at the same operative session or encounter on the same patient, on the same date of service, and for which separate billings are made. Mutually exclusive services may also include different service code descriptions for the same type of services in which the Physician should be submitting only

one (1) of the codes. One (1) or more of the duplicative services is not reimbursable as it should be reimbursed only one time.

(2) The Allowable Charge includes all services performed at the same encounter. Any and all services, which are not considered Medically Necessary will not be covered.

3. Assistant Surgeon

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

4. Anesthesia

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

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

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

5. Second Surgical Opinion

Consultation and directly related Diagnostic Services to confirm the need for elective Surgery are covered. Second or third opinion consultant must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory in order to receive Benefits.

B. Inpatient Medical Services

Subject to provisions in the sections for Surgery and Pregnancy Care, Inpatient Medical Services include:

1. Inpatient medical care visits;

2. Concurrent Care; and

3. Consultation (as defined in this Benefit Plan).

C. Outpatient Medical and Surgical Services

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

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

3. Diagnostic Services;

4. Services of an Ambulatory Surgical Center; and

5. Services of an Urgent Care Center.

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

Prescription Drugs are covered as shown in either one of the options shown below. Refer to Your Schedule of Benefits to see which Prescription Drug Benefit applies to You.

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

B. Some pharmacies have contracted with Us or with Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are Participating Pharmacies. Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is based on the amount We pay Our Pharmacy Benefit Manager. We use the amount we Pay Our Pharmacy Benefit Manager to base Our payment for the Member's Covered Prescription Drugs and the amount that the Member must pay for covered Prescription Drugs. To obtain contact information for Participating Pharmacies, the Member should contact Our customer service department or Our Pharmacy Benefit Manager at the telephone number on the ID card.

C. The Member should present the ID card to the pharmacist when purchasing covered Prescription Drugs at a Participating Pharmacy. The Deductible Amount must be satisfied before any Coinsurance will apply. If the Member has not met his Deductible Amount, the Participating Pharmacy may collect one hundred percent (100%) of the discounted cost of the drug at the point of sale. If the member has met his Deductible Amount, he will pay the Coinsurance shown on the Schedule of Benefits. The Participating Pharmacy will electronically submit the Claim for the Member.

D. Prescription Drug Formulary

This Benefit Plan covers Prescription Drugs and uses either an open or closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Benefit Plan. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost You less than drugs on higher tiers. For covered drugs that are listed on the formulary, Our Drug Utilization Management Program, more fully described in the section below, may apply.

Information about Your formulary is available to You in several ways. Most Members receive information from Us by accessing the pharmacy section of Our website at **www.bcbsla.com/pharmacy** or request a copy by mail by calling Our Pharmacy Benefit Manager at the telephone number indicated on the ID card. You may also contact Us at the telephone number on the ID card to ask whether a specific drug is included in Your formulary. If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your prescribing healthcare Provider will prescribe the drug for a particular medical condition or mental illness.

1. Open Prescription Drug Formulary

With an open formulary, Company automatically includes new Prescription Drugs to Your coverage when drug manufacturers release these new drugs for sale.
You may file a written Appeal to Us if a Prescription Drug is not included in the formulary and Your prescribing healthcare Provider has determined that the drug is Medically Necessary for You. Instructions for filing an Appeal are included in this policy.

Open Formulary – (Two Tier)

After the Deductible Amount has been met, Benefits for Prescription Drugs dispensed at retail or through the mail will be provided at the applicable Coinsurance shown in the Schedule of Benefits. Generic Drugs

and Brand-Name Drugs may be subject to different Coinsurance Amounts.

a) Tier 1: Generic Drugs

b) Tier 2: Brand-Name Drugs

2. Closed Prescription Drug Formulary

A closed formulary means that selected Brand-Name Drugs, Generic Drugs, and Specialty Drugs when listed on the formulary are covered. Drugs that are not listed on the closed formulary, also called non-formulary drugs, are not covered.

For Prescription Drugs that are not included in Our Prescription Drug Formulary, there is a formulary exception process. This process allows You, Your designee or Your prescribing healthcare Provider to ask for a formulary exception from Us. This request must be based on Medical Necessity. If the request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary. If the request is not approved, You may file an internal or external formulary exception request to Us.

Closed Formulary – (Two Tier)

(1) After the applicable Deductible Amount has been met, Benefits for Prescription Drugs dispensed at retail or through the mail will be provided at the applicable Coinsurance shown on the Schedule of Benefits. Generic Drugs and Brand-Name Drugs may be subject to different Coinsurance.

(2) If a formulary exception request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary at the applicable Generic Drug or Brand-Name Drug cost share.

a) Tier 1: Generic Drugs

b) Tier 2: Brand-Name Drugs

E. Drug Utilization Management Program

Our Drug Utilization Management Program features a set of closely aligned programs that are designed to promote Member safety, appropriate and cost-effective use of medications, and monitor healthcare quality. Examples of these programs include:

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

2. Safety checks – Before the Member's prescription is filled, Our Pharmacy Benefit Manager or We perform quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g. refill prior to seventy-five percent (75%) day supply used).

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

4. Step Therapy – Certain drugs and/or drug classes are subject to Step Therapy. In some cases, We may require the Member to first try one or more Prescription Drugs to treat a medical condition before We will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the

Member's medical condition, We may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then We will cover a prescription written for Drug B. However, if Your Physician request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the drug.

5. Step Therapy Overrides – Your healthcare Provider prescribing the Prescription Drug may request a Step Therapy override.

    a. Step Therapy overrides are provided for stage-four advanced, metastatic cancer or associated conditions when certain criteria exist; step therapy overrides are also provided for other conditions when certain criteria are met.

    b. When a Step Therapy Override request is submitted, We will respond to the request within seventy-two (72) hours unless exigent circumstances exist, in which case We will respond to the request within twenty-four (24) hours. If We do not make the determination timely, then the override request is considered approved.

    c. If a Step Therapy Override request is denied, an Appeal can be submitted.

F. Select diabetic supplies, including, but not limited to, necessary continuous glucose monitors and associated supplies, insulin syringes, and test strips are covered under the Prescription Drug Benefita.

G. When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our Pharmacy Benefit Manager or when a Member files a paper Claim with Us or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that the Company pays Our Pharmacy Benefit Manager for covered Prescription Drugs.

H. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Member should submit Claims on Our Prescription Drug Claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Member should contact Us or Our Pharmacy Benefit Manager at the telephone number indicated on the ID card.

I. As part of Our administration of Prescription Drug Benefits, We may disclose information about the Member's Prescription Drug utilization, including the names of Your prescribing Physicians, to any treating Physicians or dispensing pharmacies.

J. Any savings or rebates We receive on the cost of drugs purchased under this Benefit Plan from drug manufacturers are used to stabilize rates. Members may be subject to an excess consumer cost burden when covered prescription drugs are purchased under this Benefit Plan. (La. R.S. 22:976)

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to a Member. If a Member receives Covered Services for Preventive or Wellness from a Network Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge, unless otherwise stated below. If a Member receives Covered Services for Preventive or Wellness Care from a Non-Network Provider, Benefits will be subject to Copayment amounts (if applicable) and Coinsurance shown on the Schedule of Benefits. The Deductible Amount will apply to Covered Services received from a Non-Network Provider, unless otherwise stated below. Preventive or Wellness Care services may be subject to other limitations shown on the Schedule of Benefits.

A. Well Woman Examinations

1. Routine annual visits to an obstetrician or gynecologist. Additional visits recommended by the Member's obstetrician or gynecologist may be subject to the Deductible Amount and Coinsurance shown on the Schedule of Benefits, if not a preventive service.

2. One (1) routine Pap smear per Benefit Period.

3. All film mammograms, 3-D mammograms (digital breast tomosynthesis), and breast ultrasounds are covered at no cost to You when obtained from a Network Provider. Mammograms obtained from a Non-Network Provider will be subject to Coinsurance as shown in the Schedule of Benefits. Mammograms obtained from a Non-Network Provider will be subject to Coinsurance as shown on the Schedule of Benefits.

4. When required by applicable law, Breast MRIs will be covered under this Preventive or Wellness Care Benefit, but not at one hundred percent (100%). The Deductible Amount will not apply for Breast MRIs. Benefits will be subject to Coinsurance shown on the Schedule of Benefits for High-Tech Imaging Services. Any MRIs that are not covered under this Preventive or Wellness Care Benefit may be covered under standard plan Benefits for High-Tech Imaging Services when Medically Necessary.

B. Physical Examinations and Testing

1. Routine Wellness Physical Exam – Certain routine wellness diagnostic tests ordered by Your Physician are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Care Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels.

   High-Tech Imaging Services such as an MRI, MRA, CT scan, PET scan and nuclear cardiology are not covered under this Preventive or Wellness Care Benefit. These High-Tech Imaging Services are covered under standard plan Benefits when the tests are Medically Necessary.

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

3. Prostate Cancer Screening – One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, is covered for Members fifty (50) years of age or older, and as recommended by his Physician if the Member is over forty (40) years of age.

   A second visit shall be permitted if recommended by the Member's Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits.

4. Colorectal Cancer Screening – Fecal Immunochemical Test (FIT) for Blood, Cologuard (FIT-fecal) DNA testing, Computed Tomographic (CT) colonography, flexible sigmoidoscopy, or routine colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

Selected generic Physician prescribed colonoscopy preparation and supplies for colonoscopies covered under the Preventive or Wellness Care Benefit will be covered at no cost to You when obtained from a Network Pharmacy. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Member only under the following circumstances: Physician prescribes brand-name colonoscopy preparation and supplies because of Member's inability to tolerate selected generic colonoscopy preparation and supplies.

5. Bone Mass Measurement – scientifically proven tests for the diagnosis and treatment of osteoporosis if a Member is:

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

   b. an individual receiving long-term steroid therapy; or

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

6. BRCA1 and BRCA2 Genetic Testing **–** Genetic testing of BRCA1 and BRCA2 genes will be covered at no cost to You when obtained from a Network Provider to detect an increased risk of breast and ovarian cancer when recommended by a healthcare provider in accordance with the United States Preventive Services Task Force recommendations.

C. Immunizations

1. All state mandated immunizations including the complete basic immunization series as defined by the state health officer and required for school entry for children up to age six (6).
2. Immunizations recommended by the Member's Physician.

D. COVID-19 Services

Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by a Member's Physician for the purpose of making clinical decisions or treating a Member suspected of having COVID-19 are covered under this Plan. When a Member receives these services from a Network or Non-Network Provider, these services may be covered, up to the Network Allowable, at no cost when required by applicable law. Non-Network Providers are able to balance bill Members up to their full-billed charge. Balance bills do not apply to the Out-of-Pocket Amount. When not required by applicable law to be covered at no cost, these services are subject to standard Benefits, including applicable Deductible Amount and Coinsurance, as shown on the Schedule of Benefits for Network or Non-Network Providers.

The approved diagnostic tests and antibody tests do not include a test used for employment-related or public health surveillance testing and, regardless of medical necessity, any COVID-19 diagnostic tests or antibody tests for those purposes are excluded from coverage.

Only when required by applicable law, eight (8) approved OTC COVID-19 tests are covered for each Member every thirty (30) days. Approved OTC COVID-19 tests can be obtained from the Pharmacy Benefit Manager's direct-to-consumer shipping program method or from a pharmacy. This coverage is subject to any reimbursement limitations permitted by law.

If applicable federal or state law changes during the Benefit Period, any and all coverage for COVID-19 procedures, services, tests, or treatments will also change in accordance with those applicable laws.

E. Preventive or Wellness Care Required by the Patient Protection and Affordable Care Act

Services recommended by the United States Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration are covered. You may view a copy of Our Preventive Care Services brochure by visiting Our website at: **www.bcbsla.com/preventive**.

The list of covered services changes from time to time. To check the current list of recommended Preventive or Wellness Care services required by PPACA, visit the United States Department of Health and Human Services' website at: **http://www.healthcare.gov/preventive-care-benefits/** or contact our customer service department at the telephone number on the ID card.

Members may obtain information on the exceptions process related to the coverage of contraceptive services on Our website **bcbsla.com/birthcontrol**. This exception process is only applicable to plans which cover contraceptive services.

F. New Recommended Preventive or Wellness Care Services

New services are covered by this Benefit Plan on the date required by law for such coverage.

ARTICLE IX. MENTAL HEALTH BENEFITS

Benefits for the treatment of Mental Disorders are available. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Coverage for treatment of Mental Disorders does not include counseling services such as career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling.

ARTICLE X. SUBSTANCE USE DISORDER BENEFITS

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

ARTICLE XI. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, Providers in the Blue Connect Network, the United Concordia Dental Advantage Plus Network, or Blue Cross and Blue Shield of Louisiana's dental Network are considered Network Providers. Access these Networks at **www.bcbsla.com** or call the customer service telephone number on the ID card for a copy of the directories. Coverage is provided only for the following services or procedures:

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

B. Extraction of impacted teeth.

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

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

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

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

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

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

I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting.

J. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required to restore bodily function for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To obtain more information on how to access these medical Benefits, please call Our customer service unit at the phone number on the ID card, and ask to speak to a Case Manager.

K. Diagnosis, therapeutic, or surgical procedures related to Temporomandibular Joint Syndrome (TMJ) and associated musculature and neurological conditions. Services may require prior Authorization, as shown on Your Schedule of Benefits.

ARTICLE XII. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

Authorization is required for the evaluation of a Member's suitability for all solid organ and bone marrow transplant procedures. For the purposes of coverage under this Benefit Plan, all autologous procedures are considered transplants.

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

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplants

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or by a HMOLA Provider facility, unless otherwise approved by Us in writing.

   To locate an approved transplant facility, Members should contact Our customer service department at the number listed on the ID card.

2. Benefits for organ, tissue and bone marrow transplants include coverage for immunosuppressive drugs prescribed for transplant procedures.

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

   a. Solid Human Organ Transplants of the:

      (1) Liver;

      (2) Heart;

      (3) Lung;

      (4) Kidney;

      (5) Pancreas;

      (6) Small bowel; and

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

   b. Tissue Transplant Procedures (Autologous and Allogeneic), as specified below:

Tissue transplants (other than bone marrow) are covered under regular Benefits and do not require prior Authorization. However, if an Inpatient Admission is required, it is subject to the Care Management Article of this plan. The following tissue transplants are covered:

(1) Blood transfusions;

(2) Autologous parathyroid transplants;

(3) Corneal transplants;

(4) Bone and cartilage grafting;

(5) Skin grafting;

(6) Autologous islet cell transplants; and

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

c. Bone Marrow Transplants

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

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

ARTICLE XIII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a Member whose coverage is in effect at the time such services are furnished in connection with her pregnancy.

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

We have several maternity programs available to help pregnant Members deliver healthy babies. Please call Our customer service department at the number on the back of Your ID card when You learn You are having a baby. When You call, We will let You know what programs are available to You.

The Member must pay applicable Deductible Amounts and Coinsurances shown on the Schedule of Benefits.

A. Pregnancy Care Benefits

1. Medical and Surgical Services

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

b. Diagnostic Services

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

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

2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above are covered. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care. As determined by Us, well newborn charges may be covered if the Member under this Benefit Plan is the father.

3. Elective deliveries prior to the thirty-ninth (39th) week of gestation will be denied as not Medically Necessary unless medical records support Medical Necessity. Facility and other charges associated with an elective early delivery that is not Medically Necessary will also be denied.

4. The Family Deductible Amount, shown on the Schedule of Benefits, applies to all charges when a newborn is added to a plan of a Subscriber holding Subscriber Only coverage. This amount must be met prior to any Benefits being paid. In addition, coverage for the newborn will be pursuant to the provisions set forth in the Schedule of Eligibility Article of this plan.

   When a child is born to a Subscriber having Subscriber only coverage, the child is granted thirty (30) days of automatic coverage on the plan from the date of birth and the Deductible Amount will increase from an Individual Deductible Amount to a Family Deductible Amount. The Claim for the delivery charges may be applied to the new Family Deductible Amount.

B. Newborn Care for a Dependent Who is Covered at Birth

1. Medical and Surgical services rendered by a Physician, for treatment of illness, pre-maturity, post-maturity, congenital condition and circumcision of a newborn are covered. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.

2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, pre-maturity, post-maturity, and congenital condition of a newborn are covered. Charges for services for a well newborn, including the Hospital (nursery) charge, should not be billed separately from the mother's Hospital bill. As determined by Us, well newborn charges may be covered if the Member under this Benefit Plan is the father.

3. The Family Deductible Amount, as shown on the Schedule of Benefits, applies to all charges when a newborn is added to a plan of a Subscriber holding Subscriber Only coverage. This amount must be met prior to any Benefits being paid. In addition, coverage for the newborn will be pursuant to the provisions set forth in the Schedule of Eligibility Article of this Plan.

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

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

Also, under federal law, plans and issuers may not apply greater Deductible Amounts or Coinsurances for any later portion of the 48-hour or 96-hour stay than for any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other healthcare Provider obtain Authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours. However, to use certain Providers or facilities, or to reduce Your cost sharing, You may be required to obtain prior Authorization. For information on prior Authorization, contact Our customer service department at the number on the ID card.

ARTICLE XIV. REHABILITATIVE AND HABILITATIVE CARE BENEFITS

Rehabilitative and Habilitative Care Benefits will be available for services and devices provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation, and/or Chiropractic Services. Benefits are available when services are rendered by a Provider licensed and practicing within the scope of his license. In order for care to be considered at an Inpatient rehabilitation facility, the Member must be able to tolerate a minimum of three (3) hours of active therapy per day.

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

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

A. Occupational Therapy

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

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

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

B. Physical Therapy

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

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

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

    a. To children with a diagnosed developmental disability pursuant to the Member’s plan of care;

    b. As part of a Home Health Care agency pursuant to the Member’s plan of care;

    c. To a patient in a nursing home pursuant to the Member’s plan of care;

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

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

C. Speech/Language Pathology Therapy

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

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

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

D. Chiropractic Services

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

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

ARTICLE XV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

The following Benefits are available to a Member, subject to other limitations shown on the Schedule of Benefits.

A. Acupuncture Benefits

Your Plan covers acupuncture when services are Medically Necessary. Benefits are limited to twelve (12) visits per Benefit Period. All other subsequent acupuncture visits are not covered.

B. Ambulance Service Benefits

1. Ground Ambulance Transport Services

   a. Emergency Transport

      Benefits for Ambulance Services are available for local transportation for Emergency Medical Conditions only as follows:

      (1) for Members, to the nearest Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care;

      (2) for a Newly Born Infant, to the nearest Hospital or neonatal special care unit for treatment of illnesses, injuries, congenital birth defects and Complications of premature birth which require that level of care; or

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

   b. Non-Emergency Transport

      Benefits for Ambulance Services are available for local transportation of Members for medical conditions that do not present an Emergency, to obtain Medically Necessary Inpatient or Outpatient services, when the Member is bed-confined or his condition is such that the use of any other method of transportation is contraindicated. Benefits for non-Emergency transport are only available for transport to or from the nearest facility or Hospital capable of providing the Medically Necessary services.

The Member must meet all of the following criteria for bed-confinement to qualify for non-Emergency transport:

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

(2) unable to ambulate; and

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

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

2. Ground Ambulance Without Transport

Benefits are available for ambulance response and treatment at the scene, without transporting the Member to a facility for further medical care.

3. Air Ambulance Transport Services

a. Emergency Transport

Benefits for air Ambulance Services are available for Members with an Emergency Medical Condition. For Emergency Medical Conditions, the air Ambulance Service must be specifically requested by police or medical authorities present at the site with the Member in order for air Ambulance Services to be covered.

Benefits for air Ambulance Services are also available for emergency transport when the Member is in a location that cannot be reached by ground ambulance.

The air Ambulance transport is to the nearest facility or Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care.

b. Non-Emergency Transport

Benefits for non-Emergency air Ambulance Services must be Authorized by Us before services are rendered or no Benefits are available for the services. If Authorized by Us before services are rendered, Benefits for non-Emergency air Ambulance Services are available for Members, to the nearest facility or Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care. Once Authorized, you should verify the Network participation status of the air Ambulance Service Provider in the state or area the pick-up is to occur based on zip code. To locate a Network Provider in the state or area where you will be receiving services, please go to the Blue National Doctor & Hospital Finder at **http://provider.bcbs.com** or call 1-800-810-2583.

4. Ambulance Service Benefits will be provided as follows:

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

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

c. No Benefits are available if transportation is provided for a Member's comfort or convenience.

d. No Benefits are available when a Hospital transports Members between parts of its own campus or between facilities owned or affiliated with the same entity.

C. Attention Deficit/Hyperactivity Disorder

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

D. Autism Spectrum Disorders (ASD)

Autism Spectrum Disorder Benefits include, but are not limited to, the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Rehabilitative and Habilitative Care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Applied Behavior Analysis is available for coverage for the treatment of Autism Spectrum Disorder when it is determined to be Medically Necessary.

Autism Spectrum Disorder Benefits are subject to the Deductible Amount and Coinsurance that are applicable to the Benefits obtained. Example: A Member obtains speech therapy for treatment of Autism Spectrum Disorders. The Member will pay the applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.

E. Breast Reconstructive Surgical Services and Breast Cancer Long-Term Survivorship Care

1. Under the Women's Health and Cancer Rights Act, a Member who is receiving Benefits in connection with a mastectomy and elects breast reconstruction will also receive Benefits for the following Covered Services:

    a. All stages of reconstruction of the breast on which the mastectomy has been performed or reconstruction of both breasts if a bilateral mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance including but not limited to contralateral prophylactic mastectomy, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical Complications which may require additional reconstruction in the future;

    c. prostheses; and

    d. treatment of physical Complications of all stages of the mastectomy, including lymphedemas.

    These Covered Services shall be delivered in a manner determined in consultation with the Member and the Member's attending Physician, if applicable, and will be subject to any applicable Deductible Amount and Coinsurance.

2. Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. Members eligible for screenings are those who:

    a. were previously diagnosed with breast cancer;

    b. completed treatment for breast cancer;

    c. underwent bilateral mastectomy; and

    d. were subsequently determined to be clear of cancer.

    These Covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with the attending Physician and Member. Annual preventive cancer screenings under this Benefit are subject to any Deductible Amount and Coinsurance.

F. Cleft Lip and Cleft Palate Services

The following services for treatment and correction of Cleft Lip and Cleft Palate are covered:

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

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

3. Orthodontic treatment and management;

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

5. Speech-language evaluation and therapy;

6. Audiological assessments and amplification devices;

7. Otolaryngology treatment and management;

8. Psychological assessment and counseling; and

9. Genetic assessment and counseling for patient and parents.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

G. Clinical Trial Participation

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

2. A Qualified Individual under this section means a Member that:

    a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Illness;

    b. And either,

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

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

3. An Approved Clinical Trial for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Illness that:

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

        (1) The National Institutes of Health.

        (2) The Centers for Disease Control and Prevention.

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

(4) The Centers for Medicare & Medicaid Services.

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

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

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

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

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

(1) The Department of Veterans Affairs.

(2) The Department of Defense.

(3) The Department of Energy.

4. The following services are not covered:

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

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

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

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

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

a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other Life-Threatening Illness or for the prevention or early detection of such diseases.

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

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

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

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

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

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

H. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

a. Members that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by the Member's treating Provider.

b. Evaluation and training programs for diabetes self-management are covered subject to the following:

(1) The program must be determined to be Medically Necessary by a Physician and provided by a licensed healthcare professional who certifies that the Member has successfully completed the training program.

(2) The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

2. Diabetic Retinal Screening

Diabetic Members are eligible to receive retinal eye screenings to detect and prevent diabetic retinopathy and other eye Complications, once per Benefit Period, at no cost to the Member when services are rendered by a Network Provider. Additional screenings or screenings by a Non-Network Provider are covered subject to plan Benefits.

I. Dietitian Visits

Benefits are available for Outpatient visits to registered dietitians. One (1) dietitian visit is covered at no cost to Members when performed by a Network Provider. All other subsequent dietitian visits are covered at plan Benefits. Diabetics that need the services of a Dietitian should receive those services as part of their Benefits for Diabetes Education and Training for Self-Management.

J. Disposable Medical Equipment and Supplies

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

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered at the Deductible Amount and Coinsurance shown on the Schedule of Benefits.

1. Durable Medical Equipment

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

(1) It must withstand repeated use;

(2) It is primarily and customarily used to serve a medical purpose;

(3) It is generally not useful to a person in the absence of illness or injury; and

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

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

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

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

(3) When Durable Medical Equipment is approved by Us, Benefits for standard equipment will be provided toward any deluxe equipment when a Member selects deluxe equipment.

Deluxe equipment or deluxe features and functionalities of equipment are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for the Member's comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

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

(5) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or replacement of equipment damaged due to neglect or misuse will not be covered. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Benefit Plan, will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment subject to a recall within five (5) years after purchase or rental will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment will not be covered when provided under warranty.

c. Limitations in connection with Durable Medical Equipment.

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

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

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

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

(5) Regardless of Claims of Medical Necessity, deluxe equipment or deluxe features and functionalities of equipment that are not approved by Us are not covered.

2. Orthotic Devices

Benefits as specified in this section will be available for the purchase of Orthotic Devices Authorized by the Company. These Benefits will be subject to the following:

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

b. Repair or replacement of the Orthotic Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the device. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of the device will not be covered when provided under warranty or when the device is subject to a recall.

c. When Orthotic Devices are approved by Us, Benefits for standard devices will be provided toward any deluxe device when a Member selects a deluxe device.

(1) Deluxe devices or deluxe features and functionalities of equipment are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for the Member's comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

(2) Regardless of Claims of Medical Necessity, deluxe devices and deluxe features and functionalities of devices that are not approved by Us are not covered.

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

3. Prosthetic Appliances and Devices (Non-Limb)

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

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

b. Repair or replacement of the Prosthetic Appliance and Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance. The Company will determine this time-period. Regardless of Medical Necessity, repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.

c. When Prosthetic Appliances or Devices are approved by Us, Benefits for standard appliances or devices will be provided toward any deluxe appliance or device.

(1) Deluxe appliances or devices or deluxe features and functionalities of appliances or devices are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for the Member's comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

(2) Regardless of Claims of Medical Necessity, deluxe appliances or devices and deluxe features and functionalities of appliances or devices that are not approved by Us are not covered.

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

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

a. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.

b. When Prosthetic Appliances or Devices are approved by Us, Benefits for standard appliances or devices will be provided toward any deluxe appliance or device.

(1) Deluxe appliances or devices or deluxe features and functionalities of appliances or devices are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for the Member's comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

(2) Regardless of Claims of Medical Necessity, deluxe appliances or devices and deluxe features and functionalities of appliances or devices that are not approved by Us are not covered.

c. A Member may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Benefit Plan and may pay the difference between the price of the appliance or device and the Benefit payable, without financial or contractual penalty to the Provider of the appliance or device.

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

L. Erectile Dysfunction Benefits

Erectile Dysfunction services are covered under this Plan when we determine they are Medically Necessary and are subject to the following:

1. The services are available only to Members ages eighteen (18) or older.

2. Coverage is available for Surgical treatment of Erectile Dysfunction (including penile implants). These Surgical treatments require prior Authorization, as shown on Your Schedule of Benefits.

3. Coverage for penile implants is limited to one per lifetime.

4. Coverage for treatment (i.e., removal, repair, re-implantation) resulting from complications of the one covered penile implant is subject to Medical Necessity.

5. Coverage for provision of vacuum assisted devices (male vacuum erection system) will be covered as specified in the Durable Medical Equipment section of this Benefit Plan and is subject to the limitations included therein, including the five (5) year replacement limitation.

6. Sex therapy for treatment of sexual dysfunction other than Erectile Dysfunction is not covered.

M. Gene Therapy and Cellular Immunotherapy Benefits

Gene Therapy and Cellular Immunotherapy are high cost, specialized treatments administered by a limited number of trained and quality Providers. Benefits are available for these services only: (1) WHEN WRITTEN AUTHORIZATION OF MEDICAL NECESSITY IS GIVEN BY THE COMPANY PRIOR TO SERVICES BEING PERFORMED; AND (2) SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM THE COMPANY TO PERFORM YOUR PROCEDURE.

N. Genetic or Molecular Testing for Cancer

Genetic or molecular testing for cancer are covered under this Plan as required by law and when Medically Necessary.

O. Hearing Benefits

1. Hearing Benefits for Members ages 17 and under

   Benefits are available for hearing aids for covered Members ages seventeen (17) and under when obtained from a Network Provider. This Benefit is limited to one (1) hearing aid, for each ear with hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or a licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child. This Benefit is subject to payment of the applicable Deductible Amount and Coinsurance.

2. Hearing Benefits for Members ages 18 and older

   Benefits are available for hearing aids for covered Members ages eighteen (18) and older for severe hearing loss or profound hearing loss and when obtained from a Network Provider. Severe hearing loss or profound hearing loss is defined as hearing loss of 71dB or higher. This Benefit is limited to one (1) hearing aid for each ear with severe hearing loss or profound hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate for the Member.

   If more than one type of hearing aid can meet the Member's functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for the Member's needs. If the Member purchases a hearing aid that exceeds these minimum specifications, We will only pay the amount that We would have paid for the hearing aid that meets the minimum specifications, and the Member will be responsible for paying any difference in cost, without financial or contractual penalty to the Provider of the hearing aid.

   Authorization must be obtained prior to receiving a hearing aid for Members who are age eighteen (18) and older. This Benefit is subject to Medical Necessity and payment of the applicable Deductible Amount and Coinsurance.

3. Cochlear Implants and Bone Anchored Hearing Aids (BAHA)

   Benefits are available for cochlear implants and bone-anchored hearing aids (BAHA) for all eligible Members with severe hearing loss or profound hearing loss, regardless of age, the same as any other service or supply. This Benefit is subject to Medical Necessity and payment of the applicable Deductible Amount and Coinsurance.

4. Limitations in Connection with Hearing Aids or Other Hearing Devices

   Benefits for hearing aids, assistive listening devices or other devices available over-the-counter (OTC) hearing aids, assistive listening devices or other hearing devices are not covered.

Benefits for hearing aids or other hearing devices are not covered if We determine that a hearing aid, assistive listening device or other hearing device that is available over-the-counter is a clinically appropriate or suitable treatment for a Member's hearing loss.

Replacement of hearing aids and other hearing devices that are lost or damaged due to neglect or misuse are not covered.

Repair, adjustment, or replacement of hearing aids or other hearing devices are not covered when provided under warranty or when the hearing aid or other hearing devices are subject to recall.

Hearing aid repairs and supplies are not covered when provided by a Non-Network Provider. This limitation does not apply to Cochlear Implants or BAHA.

P. High-Tech Imaging Services

Medically Necessary High-Tech Imaging Services, including but not limited to MRIs, MRAs, CT scans, PET scans and nuclear cardiology are covered. These services require prior Authorization.

Q. Home Health Care

Home Health Care services provided to a Member in lieu of an Inpatient Hospital Admission are covered, and may be limited if shown in the Schedule of Benefits.

R. Hospice Care

Hospice Care is covered and may be limited if shown in the Schedule of Benefits.

S. Interpreter Expenses for the Deaf or Hard of Hearing

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

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

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

Benefits for Low Protein Food Products are limited to the treatment of the following diseases:

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

- Tyrosinemia

U. Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed Physician or received in a Hospital or other public or private facility authorized to provide lymphedema treatment. Coverage includes but is not limited to multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

V. Permanent Sterilization Procedures

Benefits are available for surgical procedures that result in permanent sterilization, including vasectomy, tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes unless shown as not Covered in the Schedule of Benefits. If covered, tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes is available as a Preventive or Wellness Care Benefit.

W. Prescription Donor Human Breast Milk

Benefits are available for Medically Necessary pasteurized donor human breast milk prescribed for a Dependent infant, until one (1) year of age, undergoing Inpatient care or Outpatient care who is medically or physically unable to receive maternal human milk or participate in breastfeeding or whose mother is medically or physically unable to produce maternal human milk in sufficient quantities. This coverage is limited to a two-month supply per infant per lifetime and is limited to prescribed donor human breast milk obtained from a member bank of the Human Milk Banking Association of North America or other source approved by Us.

X. Prescription Drugs

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

Y. Private Duty Nursing Services

1. Coverage is available to a Member for Private Duty Nursing Services when performed on an Outpatient basis and when the RN or LPN is not related to the Member by blood, marriage or adoption.

2. Private Duty Nursing Services are subject to the Deductible Amount and Coinsurance shown on the Schedule of Benefits.

3. Inpatient Private Duty Nursing Services are not covered.

4. This Benefit Plan limits coverage for Private Duty Nursing Services to four hundred (400) hours per Benefit Period.

Z. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Only sleep studies performed as a home sleep study or in a Network-accredited sleep laboratory are eligible for coverage. Members should check their Provider directory or contact a customer service representative at the number listed on the ID card to verify that a sleep laboratory is accredited.

AA. Telehealth Services and Remote Patient Therapy Services

Benefits are available to You for the diagnosis, consultation, treatment, education, care management, patient self-management, and caregiver support when You and your Provider are not physically located in the same place. Interaction between Member and Provider may take place in different ways, depending on the circumstances, but this interaction must always be suitable for the setting in which the Telehealth Services and Remote Patient Therapy services are provided.

Telehealth Services generally must be held in real time by two-way video and audio transmissions simultaneously (Synchronous). Telehealth Services does not cover telephone calls, and only when approved by Us is it allowed by methods other than simultaneous audio and video transmission.

Store Forward or Asynchronous Telehealth Services between an established Patient and their Provider may take place when an established patient sends pre-recorded video or images to a Provider via HIPAA-compliant communication, at the Provider's request, or when the data is transferred between two Providers on the patient's behalf. This method of Telehealth Services is limited to services approved by Us.

Store Forward or Asynchronous Remote Patient Therapy services between an established patient and a Provider who has an established, documented, and ongoing relationship with the patient may take place when an established patient uses an FDA-approved or FDA-authorized device to collect and electronically transmit biometric data to a Provider to be analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health condition. This method of Remote Patient Therapy services is limited to services and devices approved by Us.

In order to be covered, Remote Patient Therapy services must specifically be required for medical treatment decisions for the Member or as otherwise required by law and must collect and electronically transmit biometric data to an established Provider on at least sixteen (16) days of a thirty-day (30) period.

Unless prohibited by applicable law, the amount You pay for a Telehealth Services visit or Remote Patient Therapy visit may be different than the amount You would pay for the same Provider's service in a non-Telehealth or non-Remote Patient Therapy setting. You will pay more for a Telehealth visit or a Remote Patient Therapy visit when your Provider is not in your Network.

We have the right to determine if billing was appropriate and contains the required elements for Us to process the Claim.

In general, there is no coverage for Telehealth Services or Remote Patient Therapy services that are not within the scope of the Provider's license or fail to meet any standard of care compared to an in-person visit. Coverage does not exist for non-HIPAA compliant encounters which do not provide a system of secure communication to safeguard protected health information.

Telehealth Services, Remote Patient Therapy services, and the Providers who can render those services are determined by Us.

BB. Temporomandibular Joint Syndrome (TMJ)

Diagnosis, therapeutic, or surgical procedures related to Temporomandibular Joint Syndrome (TMJ) and associated musculature and neurological conditions. Services may require prior Authorization, as shown on Your Schedule of Benefits.

ARTICLE XVI. CARE MANAGEMENT

A. Authorization of Admissions, Services and Supplies, Selection of Provider, and Penalties

1. Authorization and Selection of Provider

   Benefits will be paid at the highest Network level when care is received from a Network Provider.

   a. If a Member wants to receive services from a Non-Network Provider and obtain Network Benefits, he must notify Our Care Management Department before services are rendered. We will approve the use of a Non-Network Provider only if We determine that the services **cannot** be provided by a Network Provider within a 75-mile radius of the Member's home. The Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number on the ID card or follow the instructions in the Provider Manual, if available to the Non-Network Provider.

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

   b. If We do approve the use of a Non-Network Provider, that Provider may or may not accept the Member's Deductible Amount and Coinsurance at the time services are rendered. We will pay Benefits up to the Allowable Charge for Covered Services rendered by an approved Non-Network Provider who has obtained any required Authorizations prior to services being rendered. We will deduct from Our payment the amount of the Member's Deductible Amount and Coinsurance whether or not the Deductible Amount and Coinsurance is accepted by the Non-Network Provider.

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

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

   If Authorization is not requested prior to Admission or receiving other Covered Services and supplies requiring an Authorization, We will have the right to determine if the Admission or other Covered Services and supplies were Medically Necessary. If the services were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Member must pay all charges incurred.

   If the services were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services, as follows:

   a. Admissions

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

      (2) If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount shown on the Schedule of Benefits. This penalty applies to all covered Inpatient charges. The Member is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.

b. Outpatient Services, Other Covered Services and Supplies

(1) If a Network Provider fails to obtain a required Authorization, We may reduce the Allowable Charge by thirty percent (30%). This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Network Provider is responsible for all charges not covered. The Member remains responsible for any applicable Deductible Amount and applicable Coinsurance shown on the Schedule of Benefits.

(2) If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on the Schedule of Benefits. The Member is responsible for all charges not covered and remains responsible for any applicable Deductible Amount and applicable Coinsurance shown on the Schedule of Benefits.

3. Authorization of Admissions

a. Authorization of Elective Admissions

The Member is responsible for ensuring that the Provider notifies Our Care Management Department of any Elective or non-emergency Inpatient Hospital Admission. The Company must be notified prior to the Admission regarding the nature and purpose of any Elective Admission or non-emergency Admission to a Hospital's Inpatient department. To notify Us prior to the Admission, the Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number on the ID card or follow the instructions in the Provider Manual, if available to the Provider. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If a request for Authorization is denied, the Admission is not covered and the Member must pay all charges incurred during the Admission.

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

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

b. Authorization of Emergency Admissions

It is the Member’s responsibility to ensure that his Physician or Hospital, or a representative thereof, notifies Our Care Management Department of all Emergency Admissions. Within forty-eight (48) hours of the Emergency Admission, the Company must be notified regarding the nature and purpose of the Emergency Admission. The facility or Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number on the ID card or follow the instructions in the Provider Manual, if available to the Provider. We may waive or extend this time limitation if We determine that the Member is unable to timely notify or direct his representative to notify Us of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend, the Company must be notified on the next working day. The appropriate length of stay for the Emergency Admission will be determined by Us when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If Authorization is denied by Us, the Admission will not be covered and the Member must pay all charges incurred during the Admission.

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

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

c. Concurrent Review

When We Authorize a Member's Inpatient stay, We will Authorize his stay in the Hospital for a certain number of days. If the Member has not been discharged on or before the last Authorized day, and the Member needs additional days to be Authorized, the Member must make sure his Physician or Hospital contacts Us to request Concurrent Review for Authorization of additional days. This request for continued hospitalization must be made on or before the Member's last Authorized day so We can review and respond to the request that day. If We Authorize the request, We will again Authorize a certain number of days, repeating this procedure until the Member is either discharged or the Member's continued stay request is denied. To request Concurrent Review for Authorization of additional days, the Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number on the ID card or follow the instructions in the Provider Manual, if available to the Provider.

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

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

(3) Charges for non-authorized days in the Hospital that the Member must pay are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

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

Certain services, supplies, and Prescription Drugs require Our Authorization before a Member receives the services, supplies, or Prescription Drugs. The Authorizations list is shown in the Member's Schedule of Benefits. The Member is responsible for making sure his Provider obtains all required Authorizations for him before he receives the services, supplies, or Prescription Drugs.

We may need the Member's Provider to submit medical or clinical information about the Member's condition. To obtain Authorizations, the Member's Provider should contact Our Care Management Department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number on the ID card or follow the instructions in the Provider Manual, if available to the Provider.

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

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

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

B. Disease Management

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

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

C. Case Management

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

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

3. Our determination that a particular Member's medical condition renders the Member a suitable candidate for Case Management services will not obligate Us to make the same or similar determination for the Member or for any other Member: The provision of Case Management services to one Member will not entitle the Member or any other Member to Case Management services or be construed as a waiver of Our right to administer and enforce this Benefit Plan in accordance with its express terms.

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

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

    a. We determine in Our sole discretion, that a Member is no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.

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

D. Alternative Benefits

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

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

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

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

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

    a. We determine, in Our sole discretion, that the Member is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.

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

ARTICLE XVII. LIMITATIONS AND EXCLUSIONS

A. Benefits for conditions, services, Surgery, supplies and treatment that are not covered under this Benefit Plan are excluded.

B. If a Member has Complications from excluded conditions, Surgery, or treatments; Benefits for such conditions, services, Surgery, supplies and treatment are excluded.

C. Any of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown on the Schedule of Benefits.

D. Unless otherwise shown as covered on the Schedule of Benefits, the following are excluded:

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

2. Any charges exceeding the Allowable Charge.

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

4. Benefits are excluded for services, Surgery, supplies, treatment, or expenses:

   a. other than those specifically listed as covered by this Benefit Plan. Benefits are not payable for services a Member has no obligation to pay, or for which no charge or a lesser charge would be made if a Member had no health insurance coverage.

      Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions;

   b. rendered or furnished before the Member's Effective Date or after the Member's coverage terminates, except as follows: Medical Benefits in connection with an Admission will be provided for an Admission in progress on the date a Member's coverage under this Benefit Plan ends, until the end of that Admission or until a Member has reached any Benefit limitations set in this Benefit Plan, whichever occurs first;

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

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

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

   f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures;

   g. rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs, including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes whether or not coverage under such laws or programs is actually in force. This exclusion shall not apply to services rendered to a Member holding

ten (10%) percent or more ownership in the Group, if the Member has done all of the following: (1) legally opted to be excluded from workers' compensation coverage for the Group by entering into a written agreement with Group's workers' compensation carrier electing not to be covered by such coverage; (2) properly enrolled with Company in owner 24-hour health coverage; (3) furnished the Company with a copy of the written agreement between the Member and the workers' compensation carrier; (4) furnished the Company with written evidence of Member's ownership interest in Group. If this information is not submitted to Company at the time of Member's initial enrollment for health coverage, or upon acquisition of the required ownership percentage, then Member may enroll for this coverage at Member's next open enrollment opportunity;

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

i. rendered, prescribed, or otherwise provided by a Provider who is the Member, the Member's Spouse, child, stepchild, parent, stepparent or grandparent;

j. for telephone calls, video communication, text messaging, e-mail messaging, instant messaging, or patient portal communications between You and Your Provider unless specifically stated as covered under the Telehealth Services Benefit; for services billed with Telehealth codes not suitable for the setting in which the services are provided; for Telehealth Services not permitted by Us; and for Telehealth Services rendered by Providers not permitted by Us;

k. for Remote Patient Therapy services and devices unless the results are specifically required for a medical treatment decision for a Member or as required by law;

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

m. for any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan; or

n. for paternity tests and tests performed for legal purposes.

5. Benefits are excluded for services in the following categories:

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

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

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

   d. those occurring as a result of a Member's commission or attempted commission of a felony. This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Benefits are available to the Member for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or for Emergency Medical Services.

   e. for treatment of any Member detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.

6. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following:

   a. rhinoplasty;

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

c. gynecomastia;

d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Benefit Plan;

e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, Complications and/or treatment in relation to or as a result of breast implants, except for breast reconstructive services as specifically provided in this Benefit Plan;

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

g. diastasis recti;

h. biofeedback;

i. lifestyle/habit changing clinics and/or programs, except those the law requires Us to cover or those We offer, endorse, approve, or promote as a part of Your healthcare coverage under this Benefit Plan. Some of these programs may be offered as Value-Added Services and may be subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the programs.

j. wilderness camp/programs are excluded except when provided by a qualified Residential Treatment Center and approved by Us as Medically Necessary for the treatment of mental health conditions or substance use disorders;

k. treatment related to sexual dysfunctions, low sexual desire disorder or other sexual inadequacies;

l. Erectile Dysfunction services rendered to Members who are not age eighteen (18) or older;

m. industrial testing or self-help programs including, but not limited to, stress management programs, work hardening programs and/or functional capacity evaluations; driving evaluations, etc., except services required to be covered by law;

n. recreational therapy;

o. primarily to enhance athletic abilities; and/or

p. Inpatient pain rehabilitation or Inpatient pain control programs.

7. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses related to:

a. routine eye exams (except for those for diabetics shown in the Benefits section), eyeglasses or contact lenses (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered on the Schedule of Benefits;

b. eye exercises, visual training, or orthoptics;

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

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

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

f. visual therapy.

8. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment or expenses related to:

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

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

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

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

9. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment or expenses related to Gene Therapy or Cellular Immunotherapy if prior Authorization is not obtained or if the services are performed at an administering Facility that has not been approved in writing by the Company prior to services being rendered.

10. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any of the following, except as specifically provided for in this Benefit Plan:

    a. weight reduction programs;

    b. bariatric Surgery procedures including, but not limited to:

        (1) Roux-en-Y gastric bypass

        (2) Laparoscopic adjustable gastric banding

        (3) Sleeve gastrectomy

        (4) Duodenal switch with biliopancreatic diversion;

    c. removal of excess fat or skin, or services at a health spa or similar facility; or

    d. obesity or morbid obesity, except as required by law.

11. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products or prescription donor human breast milk as described in this Benefit Plan.

12. Benefits are excluded for Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered on the Schedule of Benefits:

    a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), medications used to enhance athletic performance, medications used for effects of aging on the skin, and medications used for hair loss or restoration (e.g., Propecia®, Rogaine®), except for Prescription Drugs approved by Us to treat alopecia areata or alopecia universalis;

    b. medications for obesity, weight loss, weight management, or weight maintenance (e.g., Contrave®, Qsymia®, Saxenda®, Wegovy™);

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

d. Investigational drugs and drugs used other than for the FDA approved indication along with all Medically Necessary services associated with the administration of the drug, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals or the drug is expected to provide a similar clinical outcome for the covered indication as those included in nationally accepted standards of medical practice as determined by Us;

e. fertility drugs;

f. nutritional or dietary supplements, or herbal supplements and treatments, except those required to be covered by the United States Preventive Services Task Force preventive services recommendations. Low Protein Food Products and prescription donor human breast milk are covered as described in this Benefit Plan;

g. prescription vitamins not listed as covered in the Prescription Drug Formulary (including but not limited to Enlyte);

h. drugs that can be lawfully obtained without a Physician's order, or that do not require a prescription, including over-the-counter (OTC) drugs, except those required to be covered by law;

i. selected Prescription Drugs for which there is an OTC-equivalent or for which a similar alternative exists as an OTC medication;

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

k. compounded drugs that exhibit any of the following characteristics:

   (1) are similar to a commercially available product;

   (2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval;

   (3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being administered topically);

   (4) compounded drugs that contain drug products or components of such drug products that have been withdrawn or removed from the market for reasons of safety; or

   (5) compounded prescriptions whose only ingredients do not require a prescription;

l. selected Prescription Drug products that contain more than one active ingredient (sometimes known as combination drugs);

m. Prescription Drug products that include or are packaged with a non-Prescription Drug product;

n. Prescription Drug compounding kits;

o. selected Prescription Drug products that are packaged in a way that contains more than one (1) Prescription Drug;

p. selected Prescription Drug products with multiple therapeutic alternatives, which may be available in a greater or lesser strength or different dosage form (e.g., tablet, capsule, liquid, suspension, extended release, tamper resistant);

q. Prescription Drug products that contain marijuana, including medical marijuana;

r. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;

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

t. Prescription Drugs, equipment or substances to treat sexual dysfunction, low sexual desire disorder (Addyi®) or other sexual inadequacies;

u. Prescription Drugs, equipment or substances to treat Erectile Dysfunction (e.g., Viagra®, Cialis®, Levitra®) for Members who are not age eighteen (18) or older;

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

w. growth hormone therapy, except for the treatment of chronic renal insufficiency, AIDS wasting, Turner's Syndrome, Prader-Willi syndrome, Noonan Syndrome, wound healing in burn patients, growth delay in patients with severe burns, short bowel syndrome, short stature homeobox-containing gene (SHOX) deficiency, or growth hormone deficiency when a Physician confirms the growth hormone deficiency with abnormal provocative stimulation testing;

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

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

z. topically applied prescription drug preparations that are approved by the FDA as medical devices;

aa. Prescription Drugs subject to the Step Therapy program when the Step Therapy program was not utilized or the drug was not approved by Us or Our Pharmacy Benefit Manager;

bb. Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider unless the Provider is contracted with Our Pharmacy Benefit Manager;

cc. covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include but are not limited to intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration as determined by the Company are covered under the medical Benefit and excluded under the Pharmacy Benefit Manager; and

dd. sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Member's Coinsurance and Our financial responsibility. We will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug cost is less than the Member's Coinsurance, in which case, the Member must pay the Prescription Drug cost and sales tax.

13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to a Member's home or vehicle.

14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for palliative or cosmetic care or treatment of the foot; supportive devices of the foot; and treatment of flat feet, except for Medically Necessary Surgery.

15. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded routine foot care. Benefits for a total of six (6) services, treatments or procedures for cutting or removal of corns and calluses, nail trimming or debriding are covered. Benefits are limited to a total of six (6) services, treatments, or

procedures per Benefit Period whether such services, treatments, or procedures are provided by Network or Non-Network Providers. All other services, treatments, or procedures in excess of this limit are not covered.

16. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any abortion other than to save the life of the mother.

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

18. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.

19. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.

20. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.

21. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for acupuncture when used to provide treatment for a condition or service that is excluded from coverage under this Benefit Plan.

22. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Cosmetic Surgery, piercings, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly or Mastectomy. Complications resulting from any of these items or any other non-covered items are excluded.

23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits. This exclusion does not apply to Cleft Lip and Cleft Palate Services. Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies or Equipment Article of this Benefit Plan.

24. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for diagnosis, treatment, or Surgery of dentofacial anomalies including, but not limited to, malocclusion, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition, except as required by law. This exclusion does not apply to Cleft Lip and Cleft Palate Services. Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies or Equipment Article of this Benefit Plan.

25. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.

26. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for travel expenses of any kind or type other than covered Ambulance Services to the closest hospital equipped to adequately treat your condition, except as specifically provided in this Benefit Plan, or as approved by Us.

27. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Repatriation of remains from an international location back to the United States is not covered. Private or commercial air or sea transportation is not covered. Members traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to your home country and air/sea travel when ambulance is not required.

28. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This includes Applied Behavior Analysis (ABA) services that are not Habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or custodial care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law.

29. Benefits are excluded for Applied Behavior Analysis that the Company has determined is not Medically Necessary. The following is also excluded: Applied Behavior Analysis rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state; Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

30. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician office.

31. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Custodial Care, nursing home care, assisted living facility care or custodial home care, regardless of the level of care required or provided. This exclusion for Custodial Care does not apply to Habilitative Care services that are required to be covered by law. This exclusion for Custodial Care applies to Claims for Private Duty Nursing Services that are determined by Us to be Custodial Care.

32. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for hospital charges for a well newborn, except as specifically provided in this Benefit Plan.

33. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.

34. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for medical and Surgical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).

35. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for reversal of a voluntary sterilization procedure.

36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by Us.

37. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a covered Member related to:

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

    b. Pre-implantation genetic diagnosis;

    c. Preconception carrier screening; and

    d. Prenatal carrier screening except screenings for cystic fibrosis.

38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for the prophylactic storage of cord blood.

39. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for sleep studies, unless performed as a home sleep study or in a Network-accredited sleep laboratory. If a sleep study is not performed by a Network-accredited sleep laboratory, as a home sleep study or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.

ARTICLE XVIII. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

If eligibility for Group coverage ceases upon the death of the Subscriber, a surviving Spouse covered as a Dependent who is fifty (50) years of age or older, has ninety (90) days from the date of the Subscriber's death to notify Company of his election to continue the same coverage for himself, and if already covered, for his Dependent children.

- Coverage is automatic during the ninety (90) day election period. Premium is owed for this coverage. If continuation is not chosen, or if premium is not received for the ninety 90 days of automatic coverage, the ninety (90) days of automatic coverage is terminated retroactive to the end of the billing cycle in which the death occurred.

- If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Premium is owed from the last date for which premium has been paid. No physical exams are required. Premium for continuing coverage will not exceed the premium assessed for each Subscriber by class of coverage under the Group Benefit Plan.

The Group will be responsible for notifying the Spouse of the right to continue and for billing and collection of premium. However, if We have been furnished with the home address of the surviving Spouse at the time of death and have been notified by the Group in a manner acceptable to Us of the death of the Subscriber, We will notify the surviving Spouse of the right to continue.

Coverage continues on a premium-paying basis until the earliest of:

- the date premium is due and is not paid on a timely basis; or

- the date the surviving Spouse or a Dependent child becomes eligible for Medicare; or

- the date the surviving Spouse or a Dependent child becomes eligible to participate in another Group health plan; or

- the date the surviving Spouse remarries or dies; or

- the date this Group Benefit Plan ends; or

- the date a Dependent child is no longer eligible.

B. State Continuation

This section (State Continuation) is available only if the Group is not subject to Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto. A Subscriber or covered Dependent whose coverage under this Benefit Plan ends because of: 1) The Subscriber's death; or 2) The Subscriber's termination of active employment; or 3) because of the divorce of the Subscriber or a covered Member, may be entitled to continue the coverage under this Benefit Plan. The Subscriber or Dependent requesting continuation must have been continuously covered under this Benefit Plan (or another group policy that this Benefit Plan replaced) for the three (3) consecutive months immediately preceding the date this coverage would otherwise have ended.

Continuation of coverage for a Subscriber or his Dependents is **not** available if:

- the Covered Person, within thirty-one (31) days of termination of coverage, is or could have been covered by other Group coverage or a government sponsored health plan such as Medicare or Medicaid, or Group; or

- the Subscriber's or Member's coverage under this Benefit Plan terminated due to fraud or failure to pay his required contribution to premium; or

- the Covered Person is eligible for continuation of coverage under COBRA.

To elect continuation of coverage under this section, the Subscriber or Member must notify the Group in writing of his election to continue this Group health coverage and must pay any required contribution to the Group in advance. The initial contribution must be paid no later than the end of the month following the month in which the event occurred which made the Subscriber or Member eligible. (If the Dependent is eligible due to divorce, the event shall be deemed to have occurred on the date of the judgment of divorce.) A form to continue coverage is available from the Group.

Continuation of insurance under the Group policy for any Covered Person shall terminate on the earliest of the following dates:

- twelve (12) calendar months from the date coverage would have otherwise ended; or
- the date ending the period for which the Subscriber or Dependent makes his last required premium contribution for the coverage; or
- the date the Subscriber or Member becomes or is eligible to become covered for similar Benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured, including Medicare of Medicaid; or
- the date on which the Group policy is terminated; or
- the date on which an enrolled Member of a health maintenance organization legally resides outside the service area of the Company.

C. COBRA Continuation Coverage

The following provisions are applicable only if the Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto. Please refer to the Group Human Resources Manager or Benefits Manager for details about COBRA, or the applicability of COBRA to this Benefit Plan.

What is COBRA continuation coverage?

In accordance with COBRA law, the Employees and eligible dependents of certain Employers may have the opportunity to continue their employer-sponsored healthcare coverage for a limited time, when there is a life event (also known as a “qualifying event”) that would otherwise result in the loss of coverage under the Employer’s plan. When a qualifying event causes such loss of coverage, COBRA continuation coverage must be offered to each person who is a “qualified Beneficiary.” The Subscriber, the Subscriber’s Spouse and the Subscriber’s dependent children are listed under the law as the qualified beneficiaries. COBRA continuation coverage offers the same coverage that the Plan gives to other participants or Beneficiaries who are not receiving continuation coverage. The qualified Beneficiary may be required to pay the full cost of the continuation coverage for its entire duration.

Do I have other alternatives to COBRA continuation coverage?

COBRA continuation coverage is not the only alternative Members may have when they lose coverage under this Benefit Plan. There may be other coverage options for You and Your family.

For example, You could qualify to buy individual coverage through the Health Insurance Marketplace. Losing coverage under this Benefit Plan gives You a special enrollment opportunity in the Marketplace, even when it happens outside of the Marketplace’s open enrollment period. You have sixty (60) days from when You lose coverage under this Benefit Plan to apply for special enrollment through the Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what Your premium, Deductible Amounts, and Out-of-Pocket costs will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special enrollment opportunity for

the Marketplace, and You will not be able to enroll until the Marketplace's normal enrollment period opens or Your COBRA continuation coverage is exhausted.

Additionally, You may qualify for a special enrollment opportunity for another group health plan for which You are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if You request enrollment within thirty (30) days from losing coverage under this Benefit Plan.

Therefore, We invite You to consider all Your options so You choose the one that better fits Your needs and budget.

What if I choose to get COBRA continuation coverage?

If You and Your Dependents are qualified beneficiaries and choose to get COBRA continuation coverage, You must follow all notice and time period requirements described below or You will lose Your rights. If the Group requires shorter time periods than those stated herein, the shorter time periods of the Group apply.

What are the "qualifying events"?

A "qualifying event" is any of the following events:

- termination of employment of a covered Employee for reasons other than gross misconduct;
- loss of eligibility by a covered Employee due to a reduction in the number of work hours of the Employee;
- death of a covered Subscriber;
- divorce or legal separation between a covered Subscriber and his/her Spouse;
- the covered Subscriber becomes entitled to Medicare Benefits resulting in the loss of coverage for Dependents;
- a Dependent child ceases to be an Eligible Dependent under the terms of this Benefit Plan; or
- the Employer files for a Chapter 11 bankruptcy proceeding, but only with respect to covered former Employees who retired from the Employer at any time.

NOTE: Special rules apply for certain retirees and their Dependents who lose coverage because of an Employer's Chapter 11 bankruptcy. In this event, certain retirees may elect lifetime COBRA coverage. Eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including but not limited to: the Employer ceases to provide any group health plan to any Employees or the qualified beneficiaries fail to pay the required premiums or become covered under another Employer's group health plan that does not exclude or limit Benefits for a qualified Beneficiary's Pre-Existing Conditions. COBRA continuation coverage rights under Chapter 11 bankruptcy proceedings will be determined by the bankruptcy court, and the coverage eligible Beneficiaries could receive may not be the same as the ones they had under the retiree plan before the Employer filed for Chapter 11 bankruptcy.

Do I have to provide notification of any qualifying event?

The qualified Beneficiary must give notice of the following qualifying events to the Group within 60 days of the event:

- divorce or legal separation,
- becoming entitled to Medicare, or

- a Dependent losing eligibility for coverage as a dependent child.

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

What do I have to do to get COBRA continuation coverage?

To elect continuation coverage, the qualified Beneficiary must complete a COBRA election form and furnish it to the Group timely. The option to elect continuation coverage will be offered during a period which:

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

- ends sixty (60) days after the coverage end date or sixty (60) days after the Member is notified of their right to continue coverage, whichever is the latest.

Each qualified Beneficiary has a separate right to elect continuation coverage. For example, the Employee's Spouse may elect continuation coverage even if the Employee does not. Continuation coverage may be elected for only one, several or for all Dependent children who are qualified Beneficiaries. A parent may elect to continue coverage on behalf of the Dependent children. The Employee or the Employee's Spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

How much will I have to pay for COBRA continuation coverage?

A Member may be required to pay the entire cost of continuation coverage (including both Employer and Employee contributions) plus an amount to cover administrative expenses. If continuation of coverage is elected, the qualified Beneficiary must make his first payment for continuation coverage within forty-five (45) days after the date of the election. If the qualifying Beneficiary does not make the correct first payment in full within the forty-five (45) day period, all COBRA continuation coverage rights are lost. Timely monthly payments are required thereafter to keep coverage. Member may not receive notice of payments due.

When will COBRA continuation coverage begin and how long will it last?

Once elected, COBRA continuation of coverage will begin on the coverage end date and will terminate on the earliest of the following events:

- eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the Employee became entitled to Medicare Benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified beneficiaries other than the Employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or
- thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or

- the date the Employer ceases to maintain any Group health plan for its Employees; or

- the date coverage ceases because of nonpayment of required premiums when due; or

- the date the qualified Beneficiary first becomes covered under another group health plan and Benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (NOTE: There are limitations on plans imposing Pre-Existing Condition exclusions and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).; or

- the date the qualified Beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

Can I extend my COBRA continuation coverage?

A qualified Beneficiary's right to COBRA continuation coverage will never last longer than thirty-six (36) months from the qualifying event. This maximum duration period cannot be extended, regardless of the circumstances.

Those that are receiving eighteen (18) months of continuation coverage can extend their period, as explained below, if they undergo a second qualifying event or are declared disabled by the Social Security Administration during that original eighteen (18) month period.

If a qualified Beneficiary experiences a second qualifying event other than the termination of employment or reduction of work hours while receiving eighteen (18) months of COBRA continuation of coverage, the Dependents who were qualified beneficiaries at the time of the first qualifying event, and elected COBRA continuation coverage, may qualify for up to eighteen (18) additional months of continuation of coverage, for a maximum of thirty-six (36) months. This extension may be available to Dependents receiving continuation of coverage if:

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

The second qualifying event is applicable only if the event would have caused the Dependent to lose coverage under the plan had the first qualifying event not occurred. Qualified beneficiaries must notify the Group within sixty (60) days after the date of a second qualifying event to extend the COBRA continuation coverage.

The eighteen (18) months of continuation coverage may also be extended to a maximum of twenty-nine (29) months if a qualified Beneficiary is disabled at some time during the first sixty (60) days of COBRA coverage and is determined to be disabled (as determined under Title II or XVI of the Social Security Act) by the Social Security Administration during the original eighteen (18) months of COBRA coverage.

This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries and elected COBRA continuation coverage for the original eighteen (18) months. The qualified beneficiary must notify the Group of the disability determination before the end of the initial eighteen (18) month COBRA period and within sixty (60) days from the date of the notice from the Social Security Administration of the determination of disability:

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

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

Keep Your Plan Informed of Address Changes

In order to protect You and Your family's rights, You should keep the Group informed of any changes in Your address and the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Group Plan Administrator.

D. Employee Rights Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

Employees going on a military leave of absence to perform service in the United States uniformed services (as that term is defined under USERRA) may elect to continue coverage under this Benefit Plan for up to 24

months from the date that the Employee leaves for service. Only a covered Employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the Plan immediately before him/her leaving for military service. Dependents do not have any independent right to elect USERRA continuation coverage.

To Claim USERRA continuation coverage, the Employee must properly notify the Employer that he/she is leaving to perform service in the uniformed services and apply for continuation coverage as required by the Employer.

An Employee who elects USERRA continuation coverage may be required to pay a premium. If the leave of absence lasts thirty (30) days or less, the person may be required to pay the Employee's required contribution for coverage. However, if the military leave of absence lasts more than thirty (30) days, the person may be required to pay up to 102% of the full contribution under the Plan (including both, the Employer's and the Employee's contribution for coverage).

USERRA continuation coverage may be terminated before the maximum 24-month period if:

1. The Employee fails to pay the required premiums timely, or

2. The day after the date on which the Employee is required under the law to apply for or return to a position of employment and fails to do so.

Employers subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may choose to provide USERRA continuation coverage rights concurrently with COBRA continuation coverage, as allowed by law. Each Employer acts independently in choosing how to apply this provision and is not reflective of any guidelines issued from BCBSLA. In all cases, the Employer should be consulted on how this provision applies to their Employer group sponsored plan.

Please contact Your Employer to ask for more details on how USERRA and other continuation coverage rights apply to You.

ARTICLE XIX. COORDINATION OF BENEFITS

A. Applicability

This section applies when a Member has healthcare coverage under more than one Plan. Plan is defined below.

The Order of Benefit Determination Rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its terms of coverage without concern of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed one hundred percent (100%) of the total Allowable Expense.

B. Definitions *(Applicable only to this Coordination of Benefits Article of this plan)*

1. Allowable Expense – Healthcare services or expenses, including deductibles, coinsurance or copayments, that are covered in full or in part by any Plan covering a Member. The following are examples of services or expenses that are and are not Allowable Expenses.

    a. A healthcare service or expense or a portion of a service or expense that is not covered by any of the Plans covering a Member is not an Allowable Expense.

    b. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

    c. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

    d. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

    e. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

    f. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable Expense for all Plans.

    g. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, prior authorization of admissions and preferred provider arrangements.

2. Closed Panel Plan – A Plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

3. Coordination of Benefits or COB – A provision establishing an order in which Plans pay their claims and permitting Secondary Plans to reduce their benefits so that the combined benefits of all Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. The COB provision applies to the part of the Benefit Plan providing healthcare Benefits which may be reduced because of the benefits of other Plans. Any other part of the Benefit Plan providing healthcare Benefits is separate from this Benefit Plan. This Benefit Plan may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits.

4. Custodial Parent –

   a. the parent awarded custody of a covered child by a court decree; or

   b. in the absence of a court decree, the parent with whom the covered child resides more than one half of the calendar year without regard to any temporary visitation.

5. Order of Benefit Determination Rules – Rules that determine whether this Benefit Plan is a Primary Plan or Secondary Plan when a Member has healthcare coverage under more than one Plan. When this Benefit Plan is Primary, We determine payment for Benefits first before those of any other Plan and without considering any other Plan's benefits. When this Benefit Plan is Secondary, We determine Benefits after those of another Plan and may reduce the Benefits We pay so that all Plan benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

6. Plan – Any of the following that provide benefits or services for medical or dental care or treatment. If separate Plans or contracts are used to provide coordinated coverage for members of a group, the separate Plans or contracts are considered parts of the same Plan and there is no COB among those separate Plans or contracts.

   a. Plan includes:

      (1) group and non-group insurance contracts;

      (2) health maintenance organization (HMO) contracts;

      (3) group or group-type coverage through Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured);

      (4) the medical care components of long-term care contracts, such as skilled nursing care;

      (5) the medical benefits in group or individual automobile no fault and traditional automobile or fault contracts; and

      (6) Medicare or any other governmental benefits, as permitted by law.

   b. Plan does not include:

      (1) hospital indemnity coverage benefits or other fixed indemnity coverage;

      (2) accident only coverage;

      (3) specified disease or specified accident coverage;

      (4) limited benefit health coverage as defined by state law;

      (5) school accident-type coverage except those enumerated in La. R.S. 22:1000(A)(3)(C);

      (6) benefits for non-medical components of long-term care contracts;

      (7) Medicare supplement policies;

      (8) Medicaid plans; or

      (9) coverage under other government Plans, unless permitted by law.

   Each contract for coverage under (6)(a) or (b), above, is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

7. Primary Plan – A Plan whose benefits for a covered person's healthcare coverage must be determined without taking the existence of any other Plan into consideration.

8. Secondary Plan – A Plan that is not a Primary Plan and determines its benefits after the Primary Plan pays benefits.

C. Coordination of Benefits and Order of Benefit Determinations

1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows.

   a. The Primary Plan pays or provides its benefits according to its terms of coverage and without concern of the benefits under any other Plan.

   b. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan will pay or provide benefits as if it were the Primary Plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the Closed Panel Plan.

   c. When multiple contracts providing coordinated coverage are treated as a single Plan under the Louisiana Department of Insurance (LDI) Regulation 32, then this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the Plan, the issuer designated as Primary within the Plan will be responsible for the Plan's compliance with LDI Regulation 32.

   d. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination Rules of LDI Regulation 32 decide the order in which Secondary Plans benefits are determined in relation to each other. Each Secondary Plan must take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan, which, under LDI Regulation 32, has benefits determined before those of that Secondary Plan.

   e. Except as provided in (f) below, a Plan that does not contain a Coordination of Benefits provision that is consistent with LDI Regulation 32 is always Primary unless the provisions of both Plans state that the complying Plan is Primary.

   f. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

2. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is the Secondary Plan.

3. Order of Benefit Determination

   Each Plan determines its order of benefits using the first of the following provisions that apply.

   a. Non-Dependent or Dependent Provision

      The Plan that covers the person other than as a dependent, for example, as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a dependent; and Primary to the Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed. The Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

b. Dependent Child Covered Under More Than One Plan Provision

Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows.

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(a) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(b) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This provision applies to plan years commencing after the Plan is given notice of the court decree;

(b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of subparagraph (3)(b)(1), above, will determine the order of benefits;

(c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of subparagraph (3)(b)(1), above, will determine the order of benefits; or

(d) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:

(i) The Plan covering the Custodial Parent;

(ii) The Plan covering the spouse of the Custodial Parent;

(iii) The Plan covering the non-Custodial Parent; and then

(iv) The Plan covering the spouse of the non-Custodial Parent.

(3) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraphs (3)(b)(1) or (3)(b)(2), above, shall determine the order of benefits as if those individuals were the parents of the child.

(4) For a dependent child covered under the spouse's Plan:

(e) For a dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a dependent under a spouse's Plan, the Longer or Shorter Length of Coverage Provision, below, applies.

(f) In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits will be determined by applying the birthday provision above in subparagraph (3)(b)(1) to the child's parent(s) and the spouse.

c. Active Employee or Retired or Laid-off Employee Provision

The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this provision, and as a result, the Plans do not agree on the order of benefits, this provision is ignored. This provision does not apply if the Non-Dependent or Dependent Provision, above, can determine the order of benefits.

d. COBRA or State Continuation Coverage Provision

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this provision, and as a result, the Plans do not agree on the order of benefits, this provision is ignored. This provision does not apply if the Non-Dependent or Dependent Provision, above, can determine the order of benefits.

e. Longer or Shorter Length of Coverage Provision

The Plan that covered the person as an employee, member, policyholder, subscriber or retiree for a longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

f. Fall-Back Provision

If none of the preceding provisions determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, this Benefit Plan will never pay more than We would have paid had We been the Primary Plan.

D. Effects on the Benefits of This Benefit Plan

1. When this Benefit Plan is Secondary, We may reduce Benefits so that the total Benefits paid or provided by all Plans during a plan year are not more than one hundred percent (100%) of the total Allowable Expenses. In determining the amount to be paid for any Claim, as the Secondary Plan, We will calculate the Benefits We would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under Our Benefit Plan that is unpaid by the Primary Plan. As the Secondary Plan, We may then reduce Our payment by the amount so that, when combined with the amount paid by the Primary Plan, the total Benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, as the Secondary Plan, We will credit to the Benefit Plan Deductible Amount any amounts We would have credited to the Deductible Amount in the absence of other healthcare coverage. In any event, this Benefit Plan will never pay more than We would have paid had We been the Primary Plan.

2. The difference between the Benefit payments that We would have paid had We been the Primary Plan, and the Benefit payments that We actually paid or provided shall be recorded as a benefit reserve for You or a covered family member and used by Us to pay any Allowable Expenses, not otherwise paid during the plan year. As each Claim is submitted, We will:

   a. determine Our obligation to pay or provide Benefits under the Benefit Plan;

   b. determine whether a benefit reserve has been recorded for You or Your covered family member; and

   c. determine whether there are any unpaid Allowable Expenses during the plan year.

3. If there is a benefit reserve, We will use Your or Your covered family member's benefit reserve to pay up to one hundred percent (100%) of total Allowable Expenses incurred during the plan year. At the end of

the plan year, the benefit reserve returns to zero. A new benefit reserve must be created for each new plan year.

4. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB will not apply between that Plan and other Closed Panel Plans.

You may request a copy in either paper form or electronic form of LDI Regulation 32 - Appendix C, which provides an explanation for Secondary Plans on the purpose and use of the benefit reserve and how Secondary Plans calculate claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at **https://www.ldi.la.gov/docs/default-source/documents/legaldocs/regulations/reg32-appendixc.pdf?sfvrsn=24e14b52_0.**

E. Summary

This is a summary of only a few of the provisions of Your Benefit Plan to help You understand Coordination of Benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language above, which determines Your Benefits.

1. Double Coverage

   It is common for family members to be covered by more than one healthcare Plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. When You are covered by more than one healthcare Plan, state law permits Your insurers to follow a procedure called Coordination of Benefits to determine how much each should pay when You have a Claim. The goal is to make sure that the combined payments of all Plans do not add up to more than Your covered healthcare expenses. Coordination of Benefits is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

2. Primary or Secondary

   You will be asked to identify all the Plans that cover members of Your family. We need this information to determine whether We are the Primary or Secondary benefit payer. The Primary Plan always pays first when You have a Claim. Any Plan that does not contain Your state's COB rules will always be Primary.

3. When this Benefit Plan is Primary

   If You or a family member are covered under another Plan in addition to this one, We will be Primary when:

   a. The Claim is for Your own healthcare expenses, unless You are covered by Medicare and both You and Your Spouse are retired;

   b. The Claim is for Your Spouse's healthcare expenses, who is covered by Medicare, and You are not both retired;

   c. The Claim is for the healthcare expenses of Your Dependent child who is covered by this Benefit Plan and:

      (1) You are married and Your birthday is earlier in the year than Your Spouse's or You are living with another individual, regardless of whether or not You have ever been married to that individual, and Your birthday is earlier than that other individual's birthday. This is known as the birthday provision;

      (2) You are separated or divorced and You have informed Us of a court decree that makes You responsible for Your Dependent child's healthcare expenses; or

      (3) There is no court decree, but You have custody of Your Dependent child.

4. Other Situations

a. We will be Primary when any other provisions of state or federal law require Us to be. When We are the Primary Plan, We will pay the Benefits in accordance with the terms of Your Benefit Plan, just as if You had no other healthcare coverage under any other Plan.

b. We will be Secondary whenever the rules do not require Us to be Primary. When We are the Secondary Plan, We do not pay until after the Primary Plan has paid its benefits. We will then pay part, or all of the Allowable Expenses left unpaid, as explained below. An Allowable Expense is a healthcare service or expense covered by one of the Plans, including Copayments, Coinsurance and Deductible Amounts.

(1) If there is a difference between the amount the Plans allow, We will base Our payment on the higher amount. However, if the Primary Plan has a contract with the provider, Our combined payments will not be more than the provider contract calls for. Health maintenance organizations and preferred provider organizations usually have contracts with their providers.

(2) We will determine Our payment by subtracting the amount the Primary Plan paid from the amount We would have paid if We had been Primary. We will use any savings to pay the balance of any unpaid Allowable Expenses covered by either Plan.

(3) If the Primary Plan covers similar kinds of healthcare expenses, but allows expenses that We do not cover, We will pay for those items as long as there is a balance in Your benefit reserve, as explained below.

(4) We will not pay an amount the Primary Plan did not cover because You did not follow its rules and procedures. For example, if the Plan has reduced its benefit because You did not obtain prior authorization, as required by that Plan, We will not pay the amount of the reduction, because it is not an Allowable Expense.

c. Benefit Reserve

When We are Secondary, We often will pay less than We would have paid if We had been Primary. Each time We save by paying less, We will put that savings into a benefit reserve. Each family member covered by this Benefit Plan has a separate benefit reserve. We use the benefit reserve to pay Allowable Expenses that are covered only partially by both Plans. To obtain a reimbursement, You must show Us what the Primary Plan has paid so We can calculate the savings. To make sure You receive the full Benefit or coordination, You should submit all Claims to each of Your Plans. Savings can build up in Your reserve for one plan year. At the end of the plan year any balance is erased. A new benefit reserve begins for each person the next year as soon as there are savings on Claims.

F. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person for the purpose of determining COB. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Benefit Plan must give Us any facts We need to pay the Claim.

G. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Benefit Plan. We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under this Benefit Plan. To the extent such payments are made, they discharge Us from further liability. The term payment made includes providing Benefits in the form of services, in which case the payment made will be the reasonable cash value of any Benefits provided in the form of services.

H. Right of Recovery

If the amount of the payments that We made is more than We should have paid under this COB section, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;

2. insurance companies; or

3. other organizations.

The amount of the payments made includes the reasonable cash value of any Benefits provided in the form of services.

ARTICLE XX. GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP/POLICYHOLDER AND ALL MEMBERS.

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

A. This Benefit Plan

1. This Benefit Plan, including the Group's acceptance of the Company's proposal, Application, Enrollment Forms, Benefit change forms and renewal forms and documentation, expressing the entire money and other consideration for coverage, the Schedule of Benefits, and any amendments or endorsements, constitutes the entire contract between the parties.

2. Except as specifically provided herein, this Benefit Plan will not make the Company liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations. To the extent that this Benefit Plan may be an Employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Group will be the administrator of such Employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those specifically undertaken by the Company herein. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Member for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or for Emergency Medical Services. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Company harmless in the event the Company incurs any liability as a result of the Group's failure to do so.

3. The Company will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or Employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Member's care or treatment.

4. The Company has full discretionary authority to determine eligibility for Benefits and/or to construe the terms of this Benefit Plan. Members that disagree with the Company's determination may pursue any applicable procedures available under the terms of this Benefit Plan and the law.

5. The Company shall have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Company under this Benefit Plan may be performed by the Company or any of its subsidiaries, affiliates, subcontractors, or designees.

B. Section 1557 Grievance Procedure

HMO Louisiana, Inc. does not to discriminate on the basis of race, color, national origin, sex, age or disability. HMO Louisiana, Inc. has adopted an internal grievance procedure providing for prompt resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities.

Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator, who has been designated to coordinate the efforts of HMO Louisiana, Inc. to comply with Section 1557 at the following address:

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238
800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

If You believe You have been subjected to discrimination on the basis of race, color, national origin, sex, age or disability, You may file a grievance under this procedure. It is against the law for HMO Louisiana, Inc. to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date You become aware of the alleged discriminatory action.

- A complaint must be in writing, containing Your name and address. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

- The Section 1557 Coordinator will investigate the complaint. This investigation may be informal, but it will be thorough. You are encouraged to submit evidence related to Your complaint. The Section 1557 Coordinator will maintain the files and records of HMO Louisiana, Inc. relating to such grievances. To the extent possible, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the grievance no later than 30 days after it is received.

- You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within 15 days of receiving the Section 1557 Coordinator's decision. The Section 1557 Grievance Administrator shall issue a written decision in response to the appeal no later than 30 days after it is received.

The availability and use of this grievance procedure does not prevent You from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the United States Department of Health and Human Services, Office for Civil Rights.

You can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

United States Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

HMO Louisiana, Inc. will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process.

Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

C. Benefit Plan Changes

Subject to all applicable laws and regulations, We reserve the right to modify the terms of this Benefit Plan upon not less than sixty (60) day notice to the Group. No change or waiver of any Benefit Plan provision will be effective until approved by the Company's chief executive officer or his delegate.

D. Identification Cards and Benefit Plans

We will prepare an identification (ID) card for each Subscriber. We will issue a Benefit Plan to the Group and print a sufficient number of copies of the Benefit Plan for the Group's Subscribers. At the direction of the Group, either We will deliver all materials to the Group for the Group's distribution to the Subscribers, or We will deliver the Subscriber materials directly to each Subscriber. The Subscriber's copy of the Benefit Plan shall serve as his certificate of coverage. Unless otherwise agreed between the Group and Us, the Group has the sole responsibility for distributing all such documents to Subscribers.

E. Benefits to Which Members are Entitled

1. The liability of the Company is limited to the Benefits specified in this Benefit Plan.

2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

3. Continuity of healthcare services.

    a. Upon the termination of a contractual agreement with a Provider, notification of the removal of the Provider from the Blue Connect Network will be given by Us to a Member who has begun a course of treatment by the Provider.

    b. A Member who is a continuing care patient has the right to continuity of care until the earlier of the completion of the course of treatment or 90 days after We notify the Member that the Provider has left the Blue Connect Network.

    c. A continuing care patient is one who is:

        (1) Undergoing a course of treatment for a Serious and Complex Condition;

        (2) Undergoing a course of institutional or Inpatient care;

        (3) Scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care;

        (4) Pregnant and undergoing a course of treatment for the pregnancy; or

        (5) Terminally ill, which means the medical prognosis is a life expectancy of 6 months or less, and receiving treatment for the terminal illness from the Provider.

    d. The provisions of continuity of care shall not be applicable if any one of the following occurs:

        (1) The reason for termination of a Provider's contractual agreement is a result of documented reasons relative to quality of care, or the suspension, revocation or applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.

        (2) The reason for termination of a Provider's contractual agreement is the result of fraud.

        (3) The Member voluntarily chooses to change Providers.

        (4) The Member relocates to a location outside of the geographic service area of the Provider or the Blue Connect Network.

(5) The Member's condition does not meet the requirements to be deemed a Serious and Complex Condition.

F. Notice of Member Eligibility - Employer's Personnel Data

1. The Group is solely responsible for furnishing the information required for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate Us to provide Benefits under this Benefit Plan.

2. All notification of membership or coverage changes must be on forms approved by the Company and include all information required by Us to effect changes.

3. The Group must notify Our membership and billing department of a Member's termination of coverage by completing a cancellation form (or such other form of notification acceptable to Us) and submitting it to Our offices no later than within the next billing cycle immediately following the billing cycle in which the Member or any of the Member's Dependents is terminated from the Group or eligibility for coverage ends (or any other period described in the Schedule of Benefits). The Group will also submit to Our membership and billing department evidence of a Member's or his/her Dependent's election of any applicable COBRA or state continuation of coverage following such termination within three (3) business days of the Group's receipt of signed continuation forms from the Member. The Company is under no obligation to refund any premium paid by the Group or any Member, if payment was made to the Company due to the Group's failure to timely notify the Company of a Member's or his/her Dependent's termination of coverage.

4. Requests for termination of coverage that are submitted after the period provided above will only be honored prospectively after the date of receipt and the Group will be responsible to pay all corresponding premiums until the effective date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply. Whenever the Group submits a request to the Company to terminate a Member's coverage or that of any of the Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his Dependent has made payments towards the cost of premiums for any coverage period beyond the date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Member or his Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by the Company for such purpose, and to submit any election from the individual for continuation coverage in a separate process.

5. The Group warrants the accuracy of the information it transmits to Us and understands that We will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as requested by Us.

6. The Group further agrees to indemnify Us for all expenses We may incur as a result of the Group's failure to transmit correct information in the time-period required. Indemnification includes, but is not limited to, Claim payments made on behalf of individuals that are not eligible for Benefits. Alternatively, the Company may, at its sole option, hold the Group responsible for all premium payments for Members who are not timely cancelled from coverage due to the Group's failure to timely notify the Company of terminations or changes in eligibility.

G. Termination of a Member's Coverage

1. The Company may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of this Benefit Plan. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this coverage. Any information intentionally omitted from the application or enrollment form, as to any

proposed Subscriber or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the Effective date of coverage or terminated within three (3) years of the Member's Effective Date, for fraud or intentional misrepresentation of material fact. Company will give the Member sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If Members are enrolled that are not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

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

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

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

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

   d. Upon the death of a Subscriber, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if premiums have been paid through that period. However, a surviving Spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan or enroll for individual coverage through the Company or the Exchange.

3. In the event the Group cancels this Benefit Plan or We terminate this Benefit Plan for nonpayment of the appropriate payment when due or because the Group fails to perform any obligation required by this Benefit Plan, such cancellation or termination alone will operate to end all rights of the Member to Benefits under of this Benefit Plan as of the Effective Date of such cancellation or termination. The Group shall have the obligation to notify its Members and Beneficiaries of such cancellation or termination. We shall have no such obligation to notify at the Member level.

4. In the event of the occurrence of the provisions of paragraphs a., b., c. or d. above, if the Member is an Inpatient in a Hospital on the date coverage ends, medical Benefits in connection with the Admission for that patient will end at the end of that Admission, or upon reaching any Benefit limitations set in this Benefit Plan, whichever occurs first.

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

6. When Members on the plan change, the Company reserves the right to automatically change the Subscriber's class of coverage and bill appropriate premium to reflect the Members covered.

7. Cancellation or termination will be effective at midnight on the last day of the billing cycle. Billing cycles are from the 1st to the end of the month and from the 15th of the month to the 14th of the following month.

8. When the Group's coverage ends because the plan ceases to exist or COBRA is exhausted, Members may apply for individual coverage to Company or to the Exchange.

H. Filing of Claims

1. You must file all Claims within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than fifteen (15) months from the date services were rendered.

2. Most Members with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Member. However, if the Member must file a Claim to access

their Prescription Drug Benefit, the Member must use the Prescription Drug Claim form. The Prescription Drug Claim form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Our Pharmacy Benefit Manager, whose telephone number should be found on the ID card.

I. Applicable Law and Conforming Policy

This Benefit Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law. This Benefit Plan is not subject to regulation by any state other than the State of Louisiana. This Benefit Plan shall conform to the Essential Health Benefits package and requirements. If any provision of this Benefit Plan is in conflict with any applicable law of the State of Louisiana or the United States of America, the Benefit Plan shall be automatically amended to meet the minimum requirements of the law. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

J. Time Limit for Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.

2. Any and all lawsuits, other than those related to Claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

K. Release of Information

We may request that the Member or the Provider furnish certain information relating to the Member's Claim for Benefits. We will hold such information, records, or copies of records as confidential except where in Our discretion the same should be disclosed.

L. Assignment

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

2. We reserve the right to pay Blue Connect Network Providers, HMOLA Network Providers, and/or Providers and Hospitals in Our Participating Provider Network directly instead of paying the Member.

M. Member/Provider Relationship

1. The choice of a Provider is solely the Member's.

2. The Company and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or Employees of each other for any purpose whatsoever. The Company does not render Covered Services, but only makes payment for Covered Services that the Member receives. The Company will not be held liable for any act or omission of any Provider, or for any Claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider or in any Network Provider's facilities. The Company has no responsibility for a Provider's failure or refusal to render Covered Services to the Member.

3. The use or non-use of an adjective such as HMOLA Network, Participating, and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

N. This Benefit Plan and Medicare

1. For Employers having twenty (20) or more active Employees, federal law and regulations require that each active Employee ages sixty-five (65) or older, and each active Employee's Spouse ages sixty-five (65) or older, may elect to have coverage under this Benefit Plan or under Medicare.

    a. Where such Employee or such Spouse elects coverage under this Benefit Plan, this Benefit Plan will be the primary payor of Benefits with the Medicare program the secondary payor.

    b. This Benefit Plan will not provide Benefits to supplement Medicare payments for an active Employee ages sixty-five (65) or older or for a Spouse ages sixty-five (65) or older of an active Employee where such Employee or such Spouse elects to have the Medicare program as the primary payor.

2. Under federal law, if an active Employee under age sixty-five (65) or an active Employee's Dependent under age sixty-five (65) is covered under a Group Benefit Plan of an Employer with one hundred (100) or more Employees and also has coverage under the Medicare program by reason of Social Security disability, the Group Benefit Plan is the primary payor and Medicare is the secondary payor.

3. For persons under age sixty-five (65) who are covered under this Benefit Plan and are eligible for Medicare solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Benefit Plan the secondary payor even if an eligible person has not enrolled in the Medicare program, except that during the first thirty (30) month period that such persons are eligible for Medicare Benefits solely by reason of end-stage renal disease, this Benefit Plan will be the primary payor and Medicare the secondary payor.

4. When this Benefit Plan is the primary payor, it will provide regular Benefits for Covered Services. When this Benefit Plan is the secondary payor, it will provide Benefits based on the lesser of: the Medicare approved amount or the Company's Allowable Charge. When an Allied Provider or Physician is not required by Medicare to accept the Medicare approved amount as payment in full, We will base Benefits on the lesser of: the Medicare approved amount plus Medicare's limiting charge, if applicable, or the Company's Allowable Charge.

O. Notice

Any notice required under this Benefit Plan must be in writing. Notice given to the Group will be sent to the Group's address stated in the Application for Group Coverage. Notice given to the Company will be sent to the Company's address stated in this Benefit Plan. Any notice required to be given will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Member at his address as the same appears on Our records, or to the Group at the address as the same appears on Our records. The Group, the Company, or a Member may, by written notice, indicate a new address for giving notice.

P. Job-Related Injury or Illness

The Group must report to the appropriate federal or state governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any federal or state laws and/or related programs. This Benefit Plan excludes Benefits for any services rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes. In the event that We initially extend Benefits and a compensation carrier, employer, governmental agency or program, insurer, or any other entity makes any type of settlement with the Member, with any person entitled to receive settlement when the Member dies, or if the Member's injury or illness is found to be compensable under federal or state workers' compensation laws or programs, the Group or the Member must reimburse Us for Benefits extended or direct the compensation carrier, employer, governmental agency, or program, insurer, or any other entity to make such reimbursement. We will be entitled to such reimbursement even if the settlement does not mention or excludes payment for healthcare expenses.

Q. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Company will be subrogated and will succeed to the Member's right for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute such subrogation. Our right to recover shall be subordinate to the Member's right to be made whole. We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually incurred by the Member in pursuing recovery.

2. The Member will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured, to the extent of the Benefits provided or paid under this Benefit Plan. Our right to reimbursement shall be subordinate to the Member's right to be made whole. We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by the Member in pursuing recovery.

3. The Member will take such action, furnish such information and assistance, and execute such papers as the Company may be required to facilitate enforcement of Our rights, and will take no action prejudicing Our rights and interest under this Benefit Plan. Company and its designees have the right to obtain and review Member's medical and billing records, if Company determines in its sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Benefit Plan.

4. The Member is required to notify Us of any Accidental Injury.

R. Right of Recovery

Whenever any payment for Covered Services has been made by Us in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or whenever payment has been made in error by Us for non-Covered Services, We will have the right to recover such payment from the Member or, if applicable, the Provider. As an alternative, We reserve the right to deduct from any pending Claim for payment under this Benefit Plan any amounts that We are owed by the Member or the Provider.

S. Coverage in a Department of Veterans Affairs or Military Hospital

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from Us to the extent the veteran would be eligible for Benefits for such care or services from Us if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

The United States will have the right to collect from Us the reasonable cost of healthcare services incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that the retiree or Dependent would be eligible to receive reimbursement or indemnification from Us if the retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

T. Liability of Plan Affiliates

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Plan constitutes a contract solely between Us and the Group, that We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the Association permitting Us to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that We are not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Us and that no person, entity, or organization other

than Us shall be held accountable or liable to the Group for any of Our obligations to the Group created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this Benefit Plan.

U. Out-of-Area Services

HMO Louisiana, Inc. has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (Licensees). Generally, these relationships are called Inter-Plan Arrangements. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever You obtain healthcare services outside the geographic area We serve, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of Our Service Area, You will receive it from one of two kinds of Providers. Most Providers (Participating Providers) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (Host Blue). Some Providers (Non-Participating Providers) don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits when paid as medical Benefits, and those Prescription Drug Benefits or vision care Benefits that may be administered by a third party contracted by Us to provide the specific service or services.

1. BlueCard® Program

   Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the plan. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

   When You receive Covered Services outside Our service area and the Claim is processed through the BlueCard® Program, the amount You pay for the Covered Services is calculated based on one of the following as determined by Us:

   - the billed charges for Your Covered Services; or
   - the negotiated price that the Host Blue makes available to Us; or
   - an amount determined by applicable law.

   Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price We have used for Your Claim because they will not be applied after a Claim has already been paid.

2. Special Case: Value-Based Programs

   a. BlueCard® Program

      If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator

Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

b. Negotiated (non-BlueCard® Program) Arrangements

If We have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on Your behalf, We will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, We will include any such surcharge, tax or other fee as part of the Claim charge passed on to You.

4. Non-Participating Providers Outside Our Service Area

a. Member Liability Calculation

When Covered Services are provided outside of Our service area by Non-Participating Providers, the amount You pay for such services will normally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, may govern payments for Out-of-Network Emergency Medical Services.

b. Exceptions

In certain situations, We may use other payment methods, such as billed charges for Covered Services, the payment We would make if the healthcare services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in Your Benefit Plan.

5. Blue Cross Blue Shield Global® Core

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter BlueCard® service area), You may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® service area in certain ways.

For instance, although the Blue Cross Blue Shield Global® Core assists You with accessing a Network of Inpatient, Outpatient and professional Providers, the Network is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard® service area, You will typically have to pay the Providers and submit the Claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, You should call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global® Core service center for assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible Amount and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if You paid in full at the time of

service, You must submit a Claim to receive reimbursement for Covered Services. You must contact Us to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

b. Outpatient Services

Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area will typically require You to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

c. Submitting a Blue Cross Blue Shield Global® Core Claim

When You pay for Covered Services outside the BlueCard® service area, You must submit a Claim to obtain reimbursement. For institutional and professional Claims, You should complete a Blue Cross Blue Shield Global® Core Claim form and send the Claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of Your Claim.

The Claim form is available from Us, the Blue Cross Blue Shield Global® Core service center, or online at **www.bcbsglobalcore.com**. If You need assistance with Your Claim submission, You should call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

V. HIPAA Certificates of Creditable Coverage

We will issue a certificate of Creditable Coverage or similar document to an individual, if requested within twenty-four (24) months after coverage under this Benefit Plan ceases.

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

The Medicare Modernization Act (MMA) requires groups whose policies include Prescription Drug coverage to notify Medicare-eligible Members whether their Prescription Drug coverage is creditable, which is defined to mean that the coverage is expected to pay on average as much as the standard Medicare Part D Prescription Drug coverage. The types of coverage required to provide the notices are those listed at 42 CFR 423.56(b) and includes, but is not limited to, group health plans (this would mean the Plan Sponsor), individual health insurance coverage, and Medicare supplement plans. For these groups, there are two disclosure requirements:

1. The first disclosure requirement is to provide a written disclosure notice to all Medicare-eligible Members annually who are covered under its Prescription Drug plan, prior to October 15th each year and at various times as stated in the regulations, including to a Medicare-eligible Member when they join the Plan. This disclosure must be provided to Medicare-eligible active working Members and their Dependents, Medicare-eligible COBRA Members and their Dependents, Medicare-eligible disabled Members covered under its Prescription Drug plan and any Retirees and their Dependents. The MMA imposes a late enrollment penalty on Members who do not maintain creditable coverage for a period of 63 days or longer following their initial enrollment period for the Medicare Prescription Drug Benefit. Accordingly, this information is essential to a Member's decision whether to enroll in a Medicare Part D Prescription Drug plan.

   Groups are responsible for sending the required notices. As a service to the Group and based upon enrollment data provide to Us by the Group, We shall provide, without charge, Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to Medicare-eligible Members who have Prescription Drug coverage under this Benefit Plan at the following times, or as otherwise directed by law:

   a. prior to the Medicare Part D Annual Coordinated Election Period;

   b. prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D (age-in);

   c. prior to the Effective Date of coverage for new Medicare-eligible Employees that join this Benefit Plan;

d. whenever Prescription Drug coverage under this Benefit Plan ends or changes so that it is no longer creditable or it becomes creditable; and/or

e. upon a Medicare beneficiary's request.

2. The second disclosure requirement is for groups to complete the *Online Disclosure to CMS Form* to report the creditable coverage status of their Prescription Drug Plan. The Disclosure should be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a Prescription Drug Plan, or within 30 days after any change in creditable coverage status. This requirement does not pertain to the Medicare beneficiaries for whom groups are receiving the Retiree Drug Subsidy (RDS).

   Groups are responsible for the submission of the *Online Disclosure to CMS Form*.

X. Continued Coverage When Employee Not Actively Working

As stated in the Schedule of Eligibility, an Employee must be actively working for his Employer/Group to be entitled to coverage under this Benefit Plan. Each of the following provisions are exceptions to the requirement that the Employee be actively working in order for coverage to apply. The following provisions are independent of each other and only one need apply for the Subscriber and his Dependents to be entitled to continued coverage under this Plan. If Claims are paid when the Employee was not eligible for coverage, the Company may recover the Claims payments.

1. The Company will continue coverage for the Subscriber during any leave of absence the Group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 (FMLA), the Americans with Disabilities Act or Pregnancy Discrimination Act, and any amendments or successor provisions, as long as all other eligibility criteria under the laws continues to be met. If the Subscriber's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, the Subscriber is entitled to re-enroll for coverage so long as the Group maintains coverage with the Company. If the Subscriber is not restored to active full-time employment by the end of the leave of absence period, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in Termination of a Member's Coverage section. Subscribers and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.

2. When a Subscriber has been granted a documented, approved leave of absence by the Employer Group, and the leave of absence is not due to the Subscriber's health, the Company will maintain coverage for the Subscriber and any Covered Dependents for a period not to exceed ninety (90) days. Premiums must be paid and the Subscriber must remain a bona fide Employee of the Group during the approved leave period. The Group will provide the Company with proof of the documented leave, upon request. If the Group terminates the Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in Termination of a Member's Coverage section. Subscribers and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.

Y. Our Right to Offer Premium Incentives

We may, at Our discretion, offer rebates, refunds, reductions of premium, or other items of value, in amounts or types determined by Us, for business purposes and healthcare quality and improvement purposes, including but not limited to the following purposes:

1. Encouraging Members and/or policyholders to participate in quality programs;

2. Ensuring Members and/or policyholders are better able to afford benefits packages;

3. Reducing and alleviating social determinants of health;

4. Reducing transition costs for Members and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;

5. Rewarding Members and/or policyholders for choosing lower cost, quality healthcare providers;

6. Rewarding Members and/or policyholders for selecting lower cost, quality healthcare goods and products;

7. Rewarding Members and/or policyholders for utilizing digital and other paperless forms of communication of information, including but not limited to plan documents and materials; and

8. Reducing enrollment, technology, or administration costs of Members and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

ARTICLE XXI. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Member is dissatisfied about the care or services he receives from HMO Louisiana, Inc. or one of Our Providers. If a Member wants to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

A Member may be dissatisfied about decisions We make regarding Covered Services. We consider a written Appeal as the Member's request to change an Adverse Benefit Determination made by the Company.

Your Appeal rights are outlined below, after the Complaint and Grievance Procedures. In addition to the medical Appeals rights, the Member's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of Our coverage decision when they concern Medical Necessity determinations.

We have expedited Appeal processes for situations where the time frame of the standard medical Appeals would seriously jeopardize the life or health of a covered person, or would jeopardize the covered person's ability to regain maximum function.

A. Complaint, Grievance, and Informal Reconsideration Procedures

A quality of service concern addresses Our services, access, availability or attitude and those of Our Network Providers. A quality of care concern addresses the appropriateness of care given to a Member.

1. To Register a Complaint

   A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Members may call customer service to register a Complaint. We will attempt to resolve the Member's Complaint at the time of the call.

   Medical Benefits: call Us at 1-800-599-2583 or 1-225-291-5370

2. To File a Formal Grievance

   A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Member does not feel his Complaint was adequately resolved or he wishes to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, the Member may call Our customer service department.

   Send his written Grievances to:

   HMO Louisiana, Inc.
   Appeals and Grievance Unit
   P. O. Box 98045
   Baton Rouge, LA 70898-9045

   A response will be mailed to the Member within thirty (30) business days of receipt of the Member's written Grievance.

3. Informal Reconsideration

   An Informal Reconsideration is a request by telephone, made by an authorized Provider on the Member's behalf, to speak to Our Medical Director or a peer reviewer about a Utilization Management decision that We have made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

   An Informal Reconsideration is available only for initial determinations that are requested within ten (10) days of the denial or Concurrent Review determinations. We will conduct an Informal Reconsideration within one (1) working day of Our receipt of the request.

B. Standard Appeal Procedures

Multiple requests to Appeal the same Claim, service, issue, or date of service will not be considered, at any level of review.

We offer the Member two (2) levels of Appeal. If a Member is an ERISA Member, the Member is required to complete the first level of Appeal prior to instituting any civil action under ERISA section 502(a). The second level of Appeal is voluntary. Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Member's decision whether or not to submit to this voluntary level of review will have no effect on the Member's rights to any other Benefits under the plan. No fees or costs will be imposed on the Member.

The Member should contact his Employer, Plan Administrator, Plan Sponsor, or Our customer service department at 1-800-599-2583 or 1-225-291-5370 if the Member is unsure whether ERISA is applicable. The Member may also call Our customer service department if they have questions or need assistance putting their Appeal in writing.

C. Standard Appeal Process

We will determine if a Member's Appeal is an administrative Appeal or a medical Appeal. The Appeals procedure has two (2) levels, including review by a committee at the second level on an administrative Appeal and a review by an external Independent Review Organization (IRO) on a medical Appeal.

The Member is encouraged to provide Us with all available information to help Us completely evaluate the Appeal such as written comments, documents, records, and other information relating to the Adverse Benefit Determination. We will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination.

The Member has the right to appoint an authorized representative to represent him in his Appeals. An authorized representative is a person to whom the Member has given written consent to represent him in an internal or external review of an Adverse Benefit Determination. The authorized representative may be the Member's treating Provider if the Member appoints the Provider in writing.

1. Administrative Appeals

   Administrative Appeals involve contractual issues, Rescissions, and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or Investigational.

   Administrative Appeals should be submitted in writing to:

   HMO Louisiana, Inc.
   Appeals and Grievance Unit
   P. O. Box 98045
   Baton Rouge, LA 70898-9045

   a. First Level Administrative Appeals

      If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination for first level administrative Appeals. Requests submitted to Us after one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination will not be considered.

      We will investigate the Member's concerns. If the administrative Appeal is overturned, We will reprocess the Member's Claim, if any. If the administrative Appeal is upheld, We will inform the Member of the right to begin the second level Appeal process.

The administrative Appeal decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreed that an extension of time is warranted.

b. Second Level Administrative Appeals

After review of Our first level appeal decision, if a Member is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of receipt of Our first level Appeal decision. Requests submitted to Us after sixty (60) days of receipt of Our first level Appeal decision will not be considered.

A Member Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level Appeals. The Committee's decision is final and binding.

The Committee's decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within five (5) days of the Committee meeting. Second Level Administrative Appeals are not applicable to a Rescission, which follows the External Appeals track.

2. Medical Appeals

Medical Appeals involve Adverse Benefit Determinations for Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational and any related prospective or retrospective review determination.

We offer the Member two (2) standard levels of medical Appeals, including an internal review of the initial Adverse Benefit Determination, then an external review.

Medical Appeals should be submitted in writing to:

HMO Louisiana, Inc.
Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

a. Internal Medical Appeals

If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination for internal medical Appeals. Requests submitted to Us after one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination will not be considered.

A Physician or other healthcare professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, We will reprocess the Member's Claim, if any. If the internal medical Appeal is upheld, We will inform the Member of their right to begin the External Appeal process if the Adverse Benefit Determination meets the criteria.

The internal medical Appeal decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreed that an extension of time is warranted.

b. External Medical Appeal and Rescission

For medical Appeals and Rescission, the second level will be handled by an external Independent Review Organization that is not affiliated with Us and randomly assigned by the Louisiana Department of Insurance.

A Member must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization.

If the Member still disagrees with the internal medical Appeal decision or Rescission, a written request for an External Appeal must be submitted within four (4) months of receipt of the internal medical Appeal decision or Rescission.

Requests submitted to Us after four (4) months of receipt of the internal medical Appeal decision or Rescission will not be considered. You are required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. **Appeals submitted by your Provider will not be accepted without this form completed with Your signature.**

We will provide the IRO all pertinent information necessary to conduct the Appeal. The external review will be completed within forty-five (45) days of Our receipt of the External Appeal. The IRO will notify the Member, his authorized representative, or a Provider authorized to act on the Member's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Member and Us for purposes of determining coverage under a health Benefit Plan. This Appeals process shall constitute your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary or Investigational, except to the extent that other remedies are available under State or Federal law.

D. Expedited Appeals

The expedited Appeals process is available for review of the Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize the Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard Medical Appeal decision.

An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare service for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the covered person's treating Physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Expedited Appeals are not provided for review of services previously rendered.

An Expedited Appeal shall be made available to, and may be initiated by the Member, his authorized representative, or a Provider authorized to act on the Member's behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

HMO Louisiana, Inc.
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

1. Expedited Internal Medical Appeals

In these cases, We will make a decision no later than seventy-two (72) hours of our receipt of an internal

Expedited Appeal request that meets the criteria for Expedited Appeal. In any case where the internal Expedited Appeal process does not resolve a difference of opinion between Us and the Member or the Provider acting on behalf of the Member, the Appeal may be elevated to an Expedited External Appeal.

If an Expedited internal medical Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process and timeframe.

2. Expedited External Medical Appeal

An Expedited External Appeal is a request for immediate review, by an Independent Review Organization (IRO). The request may be simultaneously filed with a request for an internal Expedited Appeal, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for Expedited External Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

For all Medical Appeals, the Office of Consumer Advocacy of the Department of Insurance is available to assist with the appeals process. You may contact the Commissioner of Insurance directly for assistance at:

Commissioner of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

E. No Surprises Act (NSA) Internal and External Appeals

The NSA added certain Member rights and protections that are eligible for internal and External Appeals. If a Member is dissatisfied about decisions We make regarding the Member's rights and protections added by the No Surprises Act, the Member may file an Appeal. Examples of the NSA Member rights and protections include the following:

1. Member cost-sharing and surprise billing for Emergency Medical Services;

2. Member cost-sharing and surprise billing protections related to care provided by Non-Network Providers at Network facilities;

3. Whether Members are in a condition to receive notice and provide Informed Consent to waive NSA protections;

4. Whether a Claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to Member cost-sharing and surprise billing; and

5. Continuity of care.

The Member is encouraged to, and should, provide Us with all available information to help Us completely evaluate the NSA Appeal such as written comments, documents, records, and other information.

We will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the determination that is the subject of the NSA appeal.

The Member has the right to appoint an authorized representative for NSA appeals. An authorized representative is a person to whom the Member has given written consent to represent the Member in an Internal Appeal or External Appeal. The authorized representative may be the Member's treating Provider if the Member appoints the Provider in writing.

1. NSA Internal Appeals

If a Member believes that We have not complied with the surprise billing and cost-sharing protections or

with continuity of care of the NSA, a written request for review must be submitted within one hundred eighty (180) days of the NSA-related Adverse Benefit Determination. Requests submitted to Us after one hundred eighty (180) days of the NSA-related Adverse Benefit Determination will not be considered.

The NSA internal Appeals request should be submitted in writing to:

HMO Louisiana, Inc.
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

If a Member has questions or needs assistance, the Member may call Our customer service department at the number on the ID card.

We will investigate the Member's concerns. If the NSA internal Appeal is overturned, We will reprocess the Member's Claim, if applicable. If the NSA Internal Appeal is upheld, We will inform the Member of the right to begin the NSA External Appeal process.

The NSA internal Appeal decision will be mailed to the Member, the Member's authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request, unless it is mutually agreed that an extension of time is warranted.

2. NSA External Appeals

If a Member disagrees with the NSA internal Appeal decision, a written request for an NSA External Appeal must be submitted within four (4) months of receipt of the NSA internal Appeal decision. Requests submitted to Us after four (4) months of receipt of the NSA internal Appeal decision will not be considered.

You are required to sign and return the form included in the NSA internal Appeal denial notice which authorizes release of medical records for review by the IRO. Appeals submitted by Your Provider will not be accepted without this form completed with Your signature.

The NSA External Appeals request should be submitted in writing to:

HMO Louisiana, Inc.
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

If the Member has questions or needs assistance, the Member may call Our customer service department at the number on the ID card.

A Member must exhaust all NSA internal Appeal opportunities prior to requesting an NSA External Appeal conducted by an IRO.

We will provide the IRO all pertinent information necessary to conduct the NSA External Appeal. The external review will be completed within forty-five (45) days of Our receipt of the request for an NSA External Appeal. The IRO will notify the Member, the Member's authorized representative, or a Provider authorized to act on the Member's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Member and Us for purposes of determining coverage under a health Benefit Plan. This NSA External Appeal process shall constitute Your sole recourse in disputes concerning whether the Company complied with the surprise billing and cost-sharing protections of the NSA, except to the extent that other remedies are available under state or federal law.

The Member may contact 1-800-985-3059 or visit **www.cms.gov/nosurprises** for more information about Member rights under the NSA.

ARTICLE XXII. ERISA RIGHTS

To the extent this is an ERISA plan, the Member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For purposes of this provision, the Group is considered the Plan Administrator and will be subject to the provisions stated below. ERISA provides that all plan participants (Members) shall be entitled to:

A. Receive Information About the Plan and Benefits

1. A Member may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Upon written request to the Plan Administrator, a Member may obtain copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. A Member may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

A Subscriber may continue healthcare coverage for himself, his Spouse, or his Dependents, if there is a loss of coverage under the plan as a result of a qualifying event. The Subscriber or Dependents may, however, have to pay for such coverage. A Member may also review this document and the Summary Plan Description governing the plan on the rules pertaining to the Member's COBRA continuation of coverage rights.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the Subscriber and other Beneficiaries. No one, including his Employer, union or any other person, may fire him or otherwise discriminate against him in any way to prevent him from obtaining a plan Benefit or exercising his rights under ERISA.

D. Enforce Member's Rights

1. If a Member's Claim for a plan Benefit is denied or ignored, in whole or in part, the Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps the Member can take to enforce the above rights. A Member must exhaust all Claims and Appeal procedures available to him before filing any suit. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the Member may file suit in Federal Court.

   In such a case, the court may require the Plan Administrator to provide the materials and pay the Member up to one-hundred, ten dollars ($110.00) a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Member has a Claim for Benefits, which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if he disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such Member may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his rights, he may seek assistance from the United States Department of Labor, or he may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the Member

is successful, the court may order the person he has sued to pay these costs and fees. If the Member loses, the court may order him to pay these costs and fees, for example, if it determines that his Claim is frivolous.

E. Assistance with Member Questions

If a Member has any questions about his plan, he should contact the Plan Administrator. If a Member has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Member may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XXIII. MAKING PLAN CHANGES AND FILING CLAIMS

HMO Louisiana, Inc. is continuing to update its online access for Members. Members may now be able to perform many of the functions described below, without contacting Our customer service department. We invite Members to log on to **www.bcbsla.com** for access to these services.

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of Our local service offices*, or from the home office of HMO Louisiana, Inc. If the Member needs to submit documentation to Us, the Member may forward it to Our home office at HMO Louisiana, Inc. at P.O. Box 98024, Baton Rouge, LA 70898-9024, or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Member has any questions about any of the information in this section, the Member may speak to his Employer or call Our customer service department at the telephone number shown on the ID card.

A. Changing Family Members

The Schedule of Eligibility lets the Member know when You may add additional family members to Your plan. Please read the Schedule of Eligibility Article and this section as they contain important information for the Member.

An Employee Enrollment / Change Form is the document that We must receive in order to enroll family Members not listed on Your original application/enrollment form. The Employee Enrollment / Change Form is used to add newborn children, newborn adopted children, a Spouse, or other Dependents. It is extremely important that You follow the timing rules in the Schedule of Eligibility. If You do not complete and return a required Employee Enrollment Change / Form to Us within the timeframes set out in the Schedule of Eligibility, it is possible that Your insurance coverage will not be expanded to include the additional family Members. Completing and returning an Employee Enrollment / Change Form is especially important when Your first Dependent becomes eligible for coverage or when You no longer have any eligible Dependents.

B. How to File Insurance Claims for Benefits

The Company and most Providers have entered into agreements that eliminate the need for a Member to personally file a Claim for Benefits. HMOLA or Participating Providers will file Claims for Members either by mail or electronically. In certain situations, the Provider may request the Member to file the Claim. If the Member's Provider does request the Member to file directly with the Company, the following information will help the Member in correctly completing the Claim form.

The ID card shows the way the name of the Subscriber (Member of the Group) appears on the Company records. (If the Member has Dependent coverage, the name(s) are recorded as shown in the enrollment information We received.) The ID card also lists the Member's contract number (ID #). This number is the identification to the Member's membership records and should be provided to Us each time a Claim is filed.

To assist in promptly handling of the Member's Claims, the Member must be sure that:

a. an appropriate Claim form is used;

b. the contract number (ID #) shown on the form is identical to the number on the ID card;

c. the patient's date of birth is listed;

d. the patient's relationship to the Subscriber is correctly stated;

e. all charges are itemized on a statement from the Provider;

f. the itemized statement from the Provider contains the Provider's name, address and tax ID number and is attached to the Claim form;

g. the date of service (date of Admission to a Hospital or other Provider) or date of treatment is correct;

h. the Provider includes a diagnosis code and a procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form); and

i. the Claim form is completed and signed by the Member and the Provider.

C. Filing Specific Claims

1. Prescription Drug Claims

   Most Members with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Members who present the ID card to a Participating Pharmacist. However, if the Member must file a Claim to access the Member's Prescription Drug Benefit, the Member must use the Prescription Drug Claim form. Members may obtain the Prescription Drug Claim form by accessing the pharmacy section of Our website **www.bcbsla.com/pharmacy**. The Prescription Drug Claim form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Our Pharmacy Benefit Manager, whose telephone number is on the ID card.

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

2. Other Medical Claims

   When You receive other medical services (clinics, Provider offices, etc.) You should ask if the Provider is a HMOLA or Participating Provider. If yes, this Provider will file Your Claim with Us. In some situations, the Providers may request payment and ask You to file. If this occurs, be sure the Claim form is complete before forwarding to HMO Louisiana, Inc. If You are filing the Claim, the Claim must contain the itemized charges for each procedure or service. NOTE: Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills.

   IMPORTANT NOTE: Itemized bills submitted with Claim forms must include the following:

   a. full name of patient;
   b. date(s) of service;
   c. description of and procedure code for service;
   d. diagnosis code;
   e. charge for service; and
   f. name and address of Provider of service.

3. Claims for Nursing Services

   A receipt must be obtained for nursing services from each nurse indicating the name of the patient and the number of days covered by each receipt. Each receipt must also be signed by the nurse with the initials RN

or LPN and registry number. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary may also need to be filed with the receipts for nursing services.

4. Claims for Durable Medical Equipment (DME)

   Charges for rental or purchase of wheelchairs, braces, crutches, etc. must be on the bill of the supplying firm, giving a description of the item rented or purchased, the date, the charge, and the patient's name. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary may also need to be filed with these bills.

5. Claims for Mental Health and Substance Use Disorders

   For help with filing a Claim for Mental Health or substance use disorders, the Member should refer to the ID card or call Our customer service department.

D. Claims Questions

Members can view information about the processing or payment of a Claim, online at **www.bcbsla.com**. Members can also write Us at the below address or call Our customer service department at the telephone number on the ID Card or visit any of Our local service offices*. If the Member calls for information about a Claim, We can help the Member better if the Member has the information at hand, particularly the contract number, patient's name and date of service.

HMO Louisiana, Inc.
P. O. Box 98024
Baton Rouge, LA 70898-9024

Remember, the Member should ALWAYS refer to the contract number in all correspondence and recheck it against the contract number on the ID Card to be sure it is correct.

*Our local service offices are located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

ARTICLE XXIV. GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

IN ADDITION TO THE GENERAL PROVISIONS FOR GROUP/POLICYHOLDER AND MEMBERS, THE FOLLOWING GENERAL PROVISIONS WILL ALSO APPLY TO THE GROUP/POLICYHOLDER.

A. Due Date for Group's Premium Payments

1. Premiums are due and payable from the Group/Policyholder in advance, prior to coverage being rendered. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. This is the premium due date.

2. Premiums are owed by the Group/Policyholder. Premiums may not be paid by third parties, including but not limited to Hospitals, pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. The Company will not accept premium payments by third parties unless required by law to do so. The fact that the Company may have previously accepted a premium from an unrelated third party does not mean that the Company will accept premiums from these parties in the future.

3. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean We will accept late premiums in the future. You may not rely on the fact that We may have previously accepted a late premium as indication that We will do so in the future.

4. Premiums must be paid in US dollars. Policyholder will be assessed a twenty-five dollar ($25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, the Company may at its sole discretion refuse to reinstate coverage.

5. If this coverage is terminated for non-payment of premium or other amounts, We may require payment of all past due amounts before agreeing to reinstate this coverage or accepting you for coverage on a future policy of insurance.

B. Change in Premium Amount

1. Premiums for this Benefit Plan may increase after the Group's first twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, We will give the Group forty-five (45) days written notice of any change in premium rates (ninety (90) days written notice for Employer groups with more than 100 enrolled Employees). We will send notice to the Group's latest address shown in Our records. Any increase in premium is effective on the date specified in the rate change notice. Continued payment of premium will constitute acceptance of the change.

2. We reserve the right to increase the premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Benefit Plan. This risk includes, but is not limited to, the right to increase the premium amount because of: (1) the addition of a newly covered person; (2) the addition of a newly covered entity; (3) a change in age or geographic location of any individual insured or policyholder; (4) or a change in the policy Benefit level from that which was in force at the time of the last rate determination. An increase in premium will become effective on the next billing date following the effective date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

C. Group to Distribute and Account for Premium Rebate

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, the Company will pay the Group/Policyholder the total rebate applicable to the Benefit Plan, and the Group, on behalf of the Company, will distribute from the rebate a pro-rata share of the rebate to each Subscriber (including but not limited to Employees, retirees, and elected officials as covered on the Group's Benefit Plan) based upon their contribution to the premium rebated. The Group shall assure appropriate notification to federal and state tax agencies and that each payment to Subscribers will be accompanied by appropriate federal and state documentation, e.g., Form 1099.

The Group shall develop and retain records and documentation evidencing accurate distribution of any rebate and shall provide such records to the Company upon request.

Such records shall include:

1. the amount of the premium paid by each Subscriber;
2. the amount of the premium paid by the Group;
3. the amount of the rebate provided to each Subscriber;
4. the amount of the rebate retained by the Group; and
5. the amount of any unclaimed rebate and how and when it will be or was distributed.

The Group will assure that any unclaimed rebate amounts will be reported in accordance with the unclaimed property laws of the applicable Subscriber's state of domicile. The Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this section of the Group Health Benefit Plan.

D. The Group's Right to Cancel the Plan

1. This plan is guaranteed issuable and renewable at the option of the Group. The Group indicates its desire to continue coverage by its timely payment of each premium as it becomes due.

2. The Group may cancel this plan for any reason.

3. To cancel the plan purchased, the Group must give the Company WRITTEN NOTICE of its intent to cancel. THE GROUP MAY NOT VERBALLY CANCEL THIS COVERAGE. THE GROUP'S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO THE COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE BENEFIT PLAN. If the Group's written notice to the Company of its intent to cancel is not accompanied by the surrendered plan, the Group's cancellation notice to the Company shall be deemed to include the Group's declaration that the Group made a good faith attempt to locate its plan and the plan is not returned because it has been lost or destroyed.

E. The Company's Right to Terminate the Plan for Nonpayment of Premium

1. Premiums are to be prepaid before coverage is rendered. The Group is considered delinquent if premiums are not paid on the due date.

2. The Company offers a thirty (30) day grace period (delinquency period) from the due date of the premium. If the premium is not received during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the plan. The Company will mail a delinquency/termination notice to the Group's address of record. We may automatically terminate the plan without further notice to the Group if We do not receive the Group's premium at Our home office within thirty (30) days of the due date (during the grace period). If We terminate this Benefit Plan for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

3. The Group/Policyholder agrees to pay reasonable costs and fees to the Company, including reasonable attorney's fees, for the Company's attempt to collect any amounts owed under this Benefit Plan, including, but not limited to, unpaid premium.

F. The Company's Right to Terminate the Plan for Reasons Other Than Nonpayment of Premium

The Company may terminate this Benefit Plan with sixty (60) days advance written notice to the Group, providing the reason for termination, if any one of the following occurs:

1. The Group commits fraud or makes an intentional misrepresentation.

2. The Group fails to comply with a material plan provision, including, but not limited to provisions relating to eligibility, Employer contributions or group participation rules. If the sole reason for termination is that the

Group's participation falls to less than one (1) Employee (only the owner is left on the plan), termination of Group coverage will be effective on the Group's next anniversary date. Otherwise, termination for a reason addressed in this paragraph will be effective after the Group receives sixty (60) days written notice.

3. In the case of Network plans, there is no longer any enrollee under the Group Benefit Plan that lives, resides, or works in the Service Area of the Company or in the area for which the Company is authorized to do business.

4. The Group's coverage is provided through a bona fide association and the Employer's membership in the association ends.

5. The Company ceases to offer this product or coverage in the market (ninety (90) days advance written notice will be given to the Group, participants, and Beneficiaries).

Advance written notice will be given to the Group in accordance with the timeframe required by law.

G. Out-of-Area Services

Please refer to the out-of-area Services section in the General Provisions – Group / Policyholder and Members Article of this Benefit Plan for further explanation of these Inter-Plan Arrangements and the BlueCard® Program.

HMO Louisiana, Inc. has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Arrangements. These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross and Blue Shield Association (Association). Whenever Members access Covered Services outside the geographic area We serve, the Claim for those services may be processed through one of these Inter-Plan Arrangements, and the other Blue Cross and/or Blue Shield Licensee (Host Blue) will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard® Program are described generally below.

1. BlueCard® Program Liability Calculation Method Per Claim

   Unless subject to a fixed to a fixed dollar, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the Participating Provider's billed charges for Covered Services or the negotiated price made available to Us by the Host Blue.

   Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to Us by the Host Blue may be represented by one of the following:

   a. An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases, or

   b. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

   c. An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

      Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for Claims already paid to Providers or anticipated

to be paid to or refunds received or anticipated to be received from Providers). However, the BlueCard® Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims. The method of Claims payment by Host Blues is taken into account by Us in determining Group's/Policyholder's premiums.

2. Special Cases: Value-Based Programs

   We have included a factor for bulk distributions from Host Blues in Group's/Policyholder's premium for Value-Based Programs when applicable under this Benefit Plan.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

   In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable We will include any such surcharge, tax or other fee as part of the Claim charge that will be used to determine any Member liability, and will use them in determining Group's/Policyholder's premium.

4. Non-Participating Providers Outside Our Service Area

   For an explanation on how liability calculations are made for the Claims of Non-Participating Providers outside Our service area, please refer to the out-of-area services section in the General Provisions – Group/Policyholder and Members Article of this Benefit Plan.

H. Health Insurance Portability and Accountability Act (Privacy and Security)

1. For purposes of this provision, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

   a. Group Health Plan as defined at 45 CFR Part 160, Sec. 160.103.

   b. Protected Health Information (PHI) as defined at 45 CFR Part 164, Sec. 164.501.

   c. Summary Health Information as defined at 45 CFR Part 164, Sec. 164.504(a).

2. Disclosing Information to the Group

   a. Sharing Summary Health Information with the Group:

      The Company may disclose Summary Health Information to the Group if the Group requests Summary Health Information for purposes of obtaining premium bids from health insurers, HMOs or other third-party payers under the Group Health Plan; or modifying, amending or terminating the Group Health Plan.

   b. Sharing PHI with the Group:

      The Company may disclose PHI to the Group to enable the Group to carry out plan administration functions only upon receipt of a certification from the Group that:

      (1) its plan documents include all of the requirements set forth in 45 CFR Part 164, Sec. 164.504(f)(2)(i), (ii) and (iii);

      (2) it has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520 (B)(1)(iii)(C); and

      (3) that such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other Benefits or Employee Benefits plan of the Group.

   c. The Group hereby agrees to abide by the Company's acknowledgement and Authorization policies with regards to the exchange of PHI in an electronic format. For example, if the Company provides

data to the Group on a compact disc, the Company may require acknowledgement that the data was received by the Group and the name of the Group representative who received the data.

I. Value-Added Services

The Company may from time to time provide Value-Added Services to the Group. These Value-Added Services may be provided to the Group directly by the Company, or indirectly by an affiliated life, health or disability insurance company, or by a third-party company. Value-Added Services are not considered Benefits under this plan or any other policy of insurance. The Policyholder is never under any obligation to accept Value-Added Services, and the Company may cease offering and paying for Value-Added Services at any time.

J. United States Economic Sanctions Laws Compliance

The Group hereby agrees to comply fully with all applicable economic sanctions and export control laws and regulations, including those regulations maintained by the United States Treasury Department's Office of Foreign Assets Control (OFAC). The Group understands that HMO Louisiana, Inc. does not authorize extending coverage to any person to whom the provision of such coverage would be receiving insurance coverage under this or other HMO Louisiana, Inc. policies, including Subscribers and their covered Dependents, against all relevant United States Government lists of persons subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to provide coverage to any person. The Group agrees that its acceptance of coverage constitutes a representation to HMO Louisiana, Inc. that all applicable laws and regulations have been complied with and that coverage is not being provided to any denied person.

Any extension of coverage in breach of the foregoing shall constitute cause for immediate termination of this Benefit Plan, and denial of Benefits for any Claims made under that coverage, and shall entitle HMO Louisiana, Inc. to indemnification from the Group for any cost, loss, damage, liability, or expense incurred by HMO Louisiana, Inc. as a result thereof. This provision shall survive termination or cancellation of this Benefit Plan.

LLHIGA NOTICE

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

A. Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association, or LLHIGA. The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage. Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer. The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Drawer 44126
Baton Rouge, Louisiana 70804

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S.22:2081 et seq. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

C. Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state; unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

D. Exclusion from Coverage

1. A person who holds a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

   a. he is eligible for protection under the laws of another state;

   b. the insurer was not authorized to do business in this state;

   c. his policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined by law, or any entity similar to any of these.

2. LLHIGA also does not provide coverage for:

    a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

    b. any policy of reinsurance (unless an assumption certificate was issued);

    c. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;

    d. dividends, premium refunds, or similar fees or allowances described under the law;

    e. credits given in connection with the administration of a policy by a group contract holder;

    f. employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;

    g. unallocated annuity contracts (which give rights to group contract holders, not individuals), except if qualified by law

    h. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;

    i. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A coverage", "Medicare Part B coverage", "Medicare Part C coverage", or "Medicare Part D coverage" and any regulations issued pursuant to those parts;

    j. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

E. Limits on Amounts of Coverage

1. The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.

2. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

    a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.

    b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.

    c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

3. In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)