



BLUE Saver

SMALL BUSINESS
HIGH DEDUCTIBLE COMPREHENSIVE
MAJOR MEDICAL BENEFIT PLAN



Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

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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.



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,

A handwritten signature in black ink, appearing to read "I. Steven Udvarhelyi". The signature is fluid and cursive, with a large initial "I" and "U".

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

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**SMALL BUSINESS BLUESAVER
HIGH DEDUCTIBLE HEALTH PLAN**

NOTICES

Plan Sponsors of grandfathered Benefit Plans are required by law to notify the group underwriting department of Blue Cross and Blue Shield of Louisiana immediately, if Your contribution rate toward the insurance premium for this coverage changes at any point during the Plan Year.

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 ID CARD.

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

We base Our payment of Benefits for Your Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom You receive Covered Services.

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

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. We do 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.

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 selected by You in consultation with Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to any applicable Deductible Amounts and Coinsurances.

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

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 the Schedule of Benefits to see which Prescription Drug Formulary applies to this plan. 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 Plan Participants less than drugs on higher tiers.

Information about the formulary is available to Plan Participants in several ways. Most Plan Participants receive information from the Claims Administrator by accessing the pharmacy section of the Claims Administrator's website, www.bcbsla.com/pharmacy.

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

OPEN PRESCRIPTION DRUG FORMULARY

With an open formulary, the Claims Administrator automatically includes new Prescription Drugs when drug manufacturers release these new drugs for sale.

Plan Participants may file a written Appeal to the Claims Administrator if a Prescription Drug is not included in the formulary and the prescribing healthcare Provider has determined that the drug is Medically Necessary. Instructions for filing an Appeal are included in this Benefit Plan.

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 the Claims Administrator's Prescription Drug Formulary, there is a drug review process. This process allows the Plan Participant, the Plan Participant's designee or the prescribing healthcare Provider to ask for a drug review from the Claims Administrator. This request must be based on Medical Necessity. If the request is approved, the Plan Participant will receive coverage for the drug that is not on the Prescription Drug Formulary. If the drug review request is not approved, the Plan Participant may file an internal or external drug review request to the Claims Administrator.

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

Plan Participants have the right to continue the coverage of any Prescription Drug that was approved or covered by the Claims Administrator for a medical condition or mental illness, at the contracted Benefit level until the renewal of the Plan Participant's current plan regardless of whether the drug has been removed from the formulary. The Plan Participant's 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 plan and is medically appropriate for the Plan Participant.

**SMALL BUSINESS BLUE SAVER
GROUP HEALTH BENEFIT PLAN**

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

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

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

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

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

FACTS ABOUT THIS HIGH DEDUCTIBLE HEALTH PLAN

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 Plan Participant 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 Blue Saver product, and who have no other no cost health coverage except for preventive care, may establish an HSA. Plan Participants 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.

This Benefit Plan describes Preferred Provider Organization (PPO) coverage. Plan Participants have an extensive Provider Network available to them – Blue Cross and Blue Shield of Louisiana's Preferred Care PPO Network. Plan Participants can also get care from Providers who are not in this Network, but Benefits will be paid at a lower level.

Plan Participants who get care from Providers in their Network will pay the least for their care and get the most value from this Benefit Plan.

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

CLAIMS ADMINISTRATOR'S PREFERRED CARE PPO PROVIDER NETWORK

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

The Preferred Care PPO Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with the Claims Administrator to participate in the Blue Cross and Blue Shield of Louisiana Preferred Care PPO Network and render services to Plan Participants. These Providers are called PPO Providers, Preferred Providers, or 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.

To obtain the highest level of Benefits available, always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Care PPO Provider before the service is rendered. Visit the Claims Administrator's website at www.bcbsla.com, or call customer service at the number on the ID card to verify that a Provider is a current Preferred Care PPO Network Provider, or to request a paper Provider directory.

A Provider's status may change from time to time. Always verify the Provider's Network status before obtaining services. A Provider may be contracted with the Claims Administrator when providing services at one location and may be considered Out-of-Network when rendering services from another location. Check the Provider directory to verify that the services are In-Network at the location where the Plan Participant is seeking care.

Additionally, Providers in the Network may be contracted to perform certain Covered Services but may not be contracted in the Network to perform other Covered Services. When a Network Provider performs services that the Network Provider is not contracted with the Claims Administrator to perform (such as certain High-Tech Imaging Services or radiology procedures), Claims for those services will be adjudicated at the Non-Network Benefit level.

The Plan Participant should always check the Provider directory to verify that the Providers' services and locations are In-Network.

RECEIVING CARE OUTSIDE THE PREFERRED CARE PPO NETWORK

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

The plan pays a lower level of Benefits when a Plan Participant uses a Provider outside the Preferred Care PPO Network. Benefits may be based on a lower Allowable Charge. Care obtained outside the Network means the Plan Participant has higher costs and pays a higher Deductible Amount and/or Coinsurance than if the Plan Participant had stayed in the Network. **These additional costs may be significant.** In addition, the plan only pays part of those charges, and it is the Plan Participant's responsibility to pay the remainder. To the extent required by applicable law, cost sharing for Emergency Medical Services will be at the Network level even if the Hospital is not in the Network.

Ask Non-Network Providers to explain their billed charges BEFORE care is received outside the Network. Review the Sample Illustration of Plan Participant Costs When Care Is Obtained At A Non-Participating Hospital prior to obtaining care outside the Network.

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

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

In the United States:

Plan Participants receive Network Benefits when Emergency and non-Emergency Covered Services are provided by PPO Providers in other states.

If Plan Participants do not go to a PPO Provider, Non-Network Benefits will apply. Covered Emergency Medical Services are subject to Network cost sharing.

Outside the United States:

Plan Participants receive Network Benefits when covered Emergency and non-Emergency Services are provided by a Blue Cross Blue Shield Global® Core Provider across the world. If Plan Participants do not go to a Blue Cross Blue Shield Global® Core Provider, Non-Network Benefits will apply. Covered Emergency Medical Services are subject to Network cost sharing.

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 PPO 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 designated PPO Provider or a Blue Cross Blue Shield Global® Core Provider to receive the highest level of Benefits.
4. Present the ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.
5. The Plan Participant must obtain any required Authorizations from Blue Cross and Blue Shield of Louisiana.

AUTHORIZATIONS

Some services and supplies require Authorization from the Claims Administrator before services are obtained. Your Schedule of Benefits lists the services, supplies, and Prescription Drugs that require this advance Authorization. The list of items and services that require Authorization can also be located on the Claims Administrator's website, www.bcbsla.com/priorauth.

No payment will be made for organ, tissue and bone marrow transplant Benefits or evaluations unless the Claims Administrator Authorizes 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 the Blue Cross and Blue Shield PPO Provider Network, unless otherwise approved by the Claims Administrator in writing. To locate an approved transplant facility, Plan Participant should contact the customer service department at the number listed on the ID card.

HOW WE DETERMINE WHAT WE PAY FOR COVERED SERVICES

When the Plan Participant uses Network Providers

Network Providers have signed a contract with the Claims Administrator to participate in the Preferred Care PPO 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 Network Provider's Allowable Charge and is used to determine the amount the plan pays for Medically Necessary Covered Services. Plan Participants who use Network Providers will receive Network Benefits and will pay the amounts shown in the Network column on the Schedule of Benefits for these Covered Services.

When the Plan Participant uses Participating Providers

Participating Providers have signed a contract with the Claims Administrator or any 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 the plan pays for Medically Necessary Covered Services.

Plan Participants who use a Participating Provider will pay more for Medically Necessary Covered Services than if a Preferred Care PPO Network Provider was used. This will result in higher costs to the Plan Participant as shown in the Non-Network column on the Schedule of Benefits. However, the Plan Participant will be protected from paying the difference between the Allowable Charge and the Provider's billed charge.

The Plan Participant has the right to file an Appeal with the Claims Administrator for consideration of Network Benefits if the Plan Participant 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 Plan Participant's home. To file an Appeal, the Plan Participant must follow the Appeal procedures in this Benefit Plan.

When the Plan Participant uses Non-Participating Providers

Non-Participating Providers do not have a contract with the HMOLA Network, with Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plans. These Providers are not in the Claims Administrator's Networks. The Claims Administrator has no fee arrangements with them. The Claims Administrator establishes an Allowable Charge for Covered Services provided by Non-Participating Providers. The Allowable Charge will be one of the following as determined by the Claims Administrator:

- (1) an amount the Claims Administrator establishes based on the choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;
- (2) an amount the Claims Administrator establishes as the Allowable Charge; or
- (3) the Provider's billed charge. The Plan Participant will receive a lower level of Benefit because they did not go to a Network Provider.

Plan Participants usually pay significant costs when using Non-Participating Providers. This is because the amount that some Providers charge for Covered Services may be higher than the established Allowable Charge. Also, Network Providers and Participating Providers waive the difference between the actual billed charge for Covered Services and the Allowable Charge, while Non-Participating Providers do not.

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

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

SAMPLE ILLUSTRATION OF PLAN PARTICIPANT COSTS WHEN CARE IS OBTAINED AT A NON-PARTICIPATING HOSPITAL

NOTE: The following example is for illustration purposes only and is not a true reflection of the Plan Participant's actual Deductible Amounts and Coinsurances. Please refer to the Schedule of Benefits to determine 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 Plan Participant goes to the Hospital, has previously met the Deductible Amount and has obtained the necessary Authorization prior to receiving a non-Emergency service. The Hospital bills \$12,000 for the Covered Service. The Claims Administrator 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 Plan Participant is responsible for all amounts not paid by the Claims Administrator, up to the Hospital's billed charge. This example illustrates the Plan Participant's costs at three different Hospitals for the same service.

The Plan Participant 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
Plan pays:	\$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
Plan Participant 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 Plan Participant billed up to the Hospital's billed charge?	NO	NO	YES \$9,500
TOTAL AMOUNT PLAN PARTICIPANT PAYS:	\$500	\$1,200	\$10,500

WHEN A PLAN PARTICIPANT PURCHASES COVERED PRESCRIPTION DRUGS

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

When a Plan Participant purchases covered Prescription Drugs from a pharmacy that has not contracted with the Claims Administrator or with its Pharmacy Benefit Manager or when a Plan Participant files a paper Claim with the Claims Administrator or with its Pharmacy Benefit Manager, the Allowable Charge is the amount that the Claims Administrator pays its Pharmacy Benefit Manager for covered Prescription Drugs.

To obtain contact information for Participating Pharmacies, contact Our customer service department or the Pharmacy Benefit Manager at the telephone number on the ID card.

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

The Claims Administrator has contracted with an outside company to perform certain administrative services related to Mental Health and substance use disorder Benefits for Plan Participants. For help with these Benefits, the Plan Participant should refer to the Schedule of Benefits, the ID card, or call the Claims Administrator's customer service department.

PLAN PARTICIPANT INCENTIVES AND VALUE-ADDED SERVICES

Sometimes the plan may offer Plan Participants coupons, discounts, and incentives to enroll in programs, such as pharmacy programs, disease management programs, and wellness programs and activities. The plan may offer Plan Participants discounts or financial incentives to use certain Providers for selected Covered Services. The plan may also offer Plan Participants the opportunity to enroll in health and non-health related programs, as Value-Added Services, to enhance the Plan Participant's experience with the Claims Administrator

or Providers. These incentives and Value-Added Services are not Benefits and do not alter or affect Plan Participant Benefits. They may be offered by the plan, affiliated companies, and selected vendors. Plan Participants are always free to reject the opportunities for incentives and Value-Added Services. The plan reserves the right to add or remove any and all coupons, discounts, incentives, programs, and Value-Added Services at any time without notice to Plan Participants.

HEALTH MANAGEMENT AND WELLNESS TOOLS AND RESOURCES

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

CUSTOMER SERVICE E-MAIL ADDRESS

Blue Cross and Blue Shield of Louisiana has consolidated Our customer service e-mails into a single, easy-to-remember address: help@bcbsla.com. Plan Participants who need to contact the Claims Administrator may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit www.bcbsla.com and click on *Need Help?* to access Our Help Center which includes Our customer service contact information.

IDENTITY PROTECTION SERVICES

Blue Cross and Blue Shield of Louisiana is committed to identity protection for its covered Plan Participants. This includes protecting the safety and security of Plan Participants' information. To support these efforts, Blue Cross and Blue Shield of Louisiana 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 Plan Participants in addressing issues that arise in relation to credit monitoring and fraud detection.

Plan Participants are eligible to enroll in this service if their Plan Sponsor has elected to participate in the service.

A Plan Participant ceases to be eligible for these services if health coverage is terminated during the Plan Year. If health coverage is terminated during the Plan Year, Identity Protection Services will be provided to the Plan Participant through 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 that is determined to be experimental or Investigational;
- B. the Plan Participant'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 the Claims Administrator 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 the Claims Administrator to render Covered Services. For coverage purposes under this Benefit Plan, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified midwives, registered Doulas, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, physician assistants, registered nurse first assistants, advanced practice registered nurse, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by the Claims Administrator 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 the Claims Administrator establishes or negotiates 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 the Claims Administrator establishes based on the choice of Medicare's published fee schedule, what Medicare pays or what Medicare allows for the service;
 - 2. an amount the Claims Administrator establishes 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 Claims Administrator may agree to provide by agreement through Case Management when it is beneficial both to the Plan Participant and to the Group.

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 Plan Participant or a Plan Participant's authorized representative to change an Adverse Benefit Determination made by the Claims Administrator.

Applied Behavior Analysis (ABA) – The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Providers of 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 Claims Administrator 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 Plan Participant's choice of Provider.

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

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

Benefits – Coverage for healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies covered under this Benefit Plan. Benefits provided by the Benefit Plan are based on the Allowable Charge for Covered Services.

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

Benefit Plan – The program established by the Group to provide Benefits for eligible Plan Participants.

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

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

Brand-Name Drug – A Prescription Drug that is a patented drug marketed by the original drug manufacturer following its Food and Drug Administration (FDA) approval, or that the Claims Administrator identifies as a Brand-Name product. The Claims Administrator classifies a Prescription Drug as a Brand-Name Drug based on a

nationally recognized pricing source, therefore all products identified as a Brand-Name by the manufacturer or pharmacy may not be classified as a Brand-Name Drug by the Claims Administrator.

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 Plan Participant's healthcare needs across the continuum of care.

Care Coordinator Fee – A fixed amount paid by Blue Cross and Blue Shield of Louisiana 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 the Plan Administrator's option and administered by medical professionals, and which focuses on unusually complex, difficult or catastrophic illnesses. Working with the Plan Participant's Physician(s) and subject to consent by the Plan Participant and/or the Plan Participant's family/caregiver, the Case Management staff will manage care to achieve the most efficient and effective use of resources.

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 – Written or electronic proof, in a form acceptable to the Claims Administrator, of charges for Covered Services that have been incurred by the Plan Participant during the time period the Plan Participant was covered 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.

Claims Administrator – The entity with whom the Group (Plan Administrator/Sponsor) has contracted to handle the claims payment functions of its Plan. For purposes of this Plan, the Claims Administrator is Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service and Indemnity Company).

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 percentage that the plan pays, and a percentage that the Plan Participant pays. Once the Plan Participant has met any applicable Deductible Amount, the Plan Participant's percentage will be applied to the Allowable Charges for Covered Services to determine the Plan Participant's financial responsibility. The plan's percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Company – Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service & Indemnity Company).

Complaint – An oral expression of dissatisfaction with the plan 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 the Claims Administrator, 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. The Claims Administrator will determine which conditions are covered as Congenital Anomalies.

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

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

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.

The Claims Administrator determines which services are Custodial Care.

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

Deductible Amounts –

- A. Individual Deductible Amount – The dollar amount shown on the Schedule of Benefits of Allowable Charges for Covered Services that a Plan Participant with Employee only coverage must pay within a Benefit Period before the plan starts paying Benefits.
- B. Family Deductible Amount – The dollar amount 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 (1) one Plan Participant, the Individual Deductible Amount is not applicable. Only the Family Deductible Amount applies. No Benefits are eligible for payment on any covered member of the family until the total Family Deductible Amount has been met. 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.

For purposes of this plan, family includes all available classes of coverage, except Employee only coverage. Family Deductible Amounts may apply to other types of Deductible Amounts described in this Benefit Plan.

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

- A. is licensed to be 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 Employee, 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 the Claims Administrator recognizes 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.

Doula – An individual who has an approved registration through the Louisiana Doula Registry Board, has met the Claims Administrator's credentialing standards, and who is trained to provide physical, emotional, and educational support, but not medical or midwifery care, to pregnant and birthing women and their families before, during, and after childbirth.

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

Effective Date – The date when a Plan Participant's coverage begins under this Benefit Plan as determined by the Schedule of Eligibility 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.

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.

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

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:

- A. 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;
- B. serious impairment to bodily function; or
- C. 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 Plan Participant 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 – The person, firm, or institution named on the Schedule of Benefits.

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.

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 Plan Participant or jeopardize the Plan Participant's ability to regain maximum function.

- B. In the opinion of the treating Physician, the Plan Participant 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 Plan Participant currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

Expedited External Appeal – A request for immediate review, by an Independent Review Organization, of an 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 Plan Participant or jeopardize the covered Plan Participant's ability to regain maximum function.
- B. A decision to not Authorize an Admission, availability of care, continued Hospital stay or healthcare services for a Plan Participant currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.
- C. A denial of coverage based on a determination that 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 Plan Participant'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 Plan Participant.

External Appeal – A request for review by an Independent Review Organization to change an initial Adverse Benefit Determination made by the Claims Administrator or to change a final Adverse Benefit Determination rendered on Appeal. An External Appeal is available upon request by the Plan Participant or the Plan Participant'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 thirty (30) or more hours per week; or (2) is working less than thirty (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 the Claims Administrator identifies as a Generic Drug. Classification of a Prescription Drug as a Generic Drug is determined by the Claims Administrator and not by the manufacturer or pharmacy. The Claims Administrator classifies a Prescription Drug as a Generic Drug based on a nationally recognized pricing source; therefore, all products identified as a Generic by the manufacturer or a pharmacy may not be classified as a Generic by the Claims Administrator.

Gestational Carrier – A woman, not covered on the Benefit 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 the plan or with Provider services.

Group – Employer or other legal entity who is the Plan Administrator and Sponsor of this Benefit Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

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.

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

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 the Claims Administrator. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse (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 Plan Participants and their families during the final stages of terminal illness. Full scope health services are centrally coordinated through an interdisciplinary team directed by a Physician and provided by or through a Hospice Care agency approved by the Claims Administrator.

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.

Iatrogenic Infertility – Impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other Medically Necessary medical treatment affecting the reproductive organs or processes.

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 the Claims Administrator, that conducts external reviews of Adverse Benefit Determinations, Rescission determinations and No Surprises Act-related decisions. The decision of the IRO is binding on both the Plan Participants and the Claims Administrator, 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 Plan Participant by a Non-Network Provider that must be executed by a Plan Participant in order for a Non-Network Provider to obtain the Plan Participant's consent to receive medical treatment and services from the Non-Network Provider without the protections provided by the No Surprises Act.

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

Intensive Outpatient Programs – An Outpatient treatment program that provides a planned and structured intensive level of care 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 Disorder and/or a substance use disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational

services, and adjunctive services such as medical monitoring. These services include multiple or extended treatment, rehabilitation, and 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 use disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here does not include times spent in these self-help programs, which are offered by community volunteers without charge.

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

- A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the 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 mean standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to:

- A. psychoses;
- B. neurotic disorders;
- C. personality disorders;

D. affective disorders;

The specific severe mental illnesses defined by La. R.S. 22:1043:

E. schizophrenia or schizoaffective disorder;

F. bipolar disorder;

G. panic disorder;

H. obsessive-compulsive disorder;

I. major depressive disorder;

J. anorexia/bulimia;

K. intermittent explosive disorder;

L. post-traumatic stress disorder;

M. psychosis NOS when diagnosed in a child under seventeen (17) years of age;

N. Rett's Disorder;

O. Tourette's Disorder; and

P. 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 Claims Administrator.

The definition of Mental Disorder (Mental Health) is the basis for determining Benefits despite 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 Network Provider. Network Benefits may also be referred to as In-Network.

Network Pharmacy – A pharmacy contracted with the Claims Administrator or its Pharmacy Benefit Manager to accept a negotiated amount as payment in full for covered Prescription Drugs they dispense to Plan Participants. Network Pharmacies may also be referred to as Participating Pharmacies.

Network Provider – A Provider that has signed an agreement with the Claims Administrator or another Blue Cross and Blue Shield plan to participate as a member of the Preferred Care PPO Provider Network or another PPO Network. This Provider may also be referred to as a Preferred 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 Non-Network Providers. Non-Network Benefits may also be referred to as Out-of-Network.

Non-Network Provider – A Provider who is not a member of the Claims Administrator's Preferred Care PPO Provider Network or another Blue Cross and Blue Shield plan PPO Network. Participating Providers and Non-Participating Providers are Non-Network Providers.

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, designated by the Group, during which an Employee and any 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, 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 Plan Participant with Employee only coverage, within a Benefit Period. After the Individual Out-of-Pocket is met, the Benefit Plan will pay one hundred percent (100%) of the Allowable Charge for Covered Services.
- B. Family Out-of-Pocket Amount – The maximum amount, 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 includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. Only the Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount is met, the Benefit 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.

Outpatient – A Plan Participant 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 Plan Participant for support, and is incapable of sustaining employment because of an intellectual or physical disability that began prior to age twenty-six (26). Coverage of the Over-Age Dependent may continue after age twenty-six (26) for the duration of incapacity if, prior to or within thirty-one (31) days of the Dependent child reaching age twenty-six (26), an application for continued coverage with current medical information from the Dependent child's attending Physician is submitted to the Claims Administrator. The Claims Administrator 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 twenty-sixth (26th) birthday. The Claims Administrator may terminate coverage of the Over-Age Dependent if it is determined that the Dependent child is no longer reliant on the Plan Participant for support or is no longer intellectually or physically disabled to the extent the Dependent child is incapable of sustaining employment.

Partial Hospitalization Programs – Programs that provide structured and medically supervised day, evening and/or night treatment for at least four (4) hours per day and three (3) days per 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 those provided in a Hospital except that patients are in the program less than twenty-four (24) hours per day. Patients are not considered a resident at the program. The range of services addresses a Mental Health and/or substance use 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 that license at the time and place service is rendered.

Plan – The Employer's medical Benefits plan for certain Employees of the Employer and is described in this document.

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

Plan Participant – Any Employee, retiree, elected official, officer, director or Dependent who is covered under this Benefit Plan.

Plan Sponsor – The person, firm or institution, who provides these Benefits on behalf of its eligible Employees, retirees, elected officials, officers, directors and their eligible Dependents.

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

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

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

Prescription Drug Coinsurance – The sharing of Allowable Charges for Prescription Drugs that this Benefit Plan covers. The sharing is expressed as a pair of percentages; a plan percentage and a Plan Participant percentage that You pay. Once the Plan Participant has met any applicable Prescription Drug Deductible Amount, the Plan Participant's percentage will be applied to the Allowable Charges for Prescription Drugs to determine how much You pay. The Claims Administrator applies its percentage to the Allowable Charges for Prescription Drugs to determine the Benefit. A different Prescription Drug Coinsurance may be required for the different drug tiers purchased at a retail pharmacy or through the mail.

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

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.

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. The Claims Administrator determines which services are Private Duty Nursing Services. Private Duty Nursing Services that are determined by the Claims Administrator 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 that license, and approved by the Claims Administrator. If a Provider is not subject to state or federal licensure, the Claims Administrator has the right to define all criteria under which a Provider's services may be offered to Plan Participants in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

- A. Preferred Provider (Preferred Care PPO Provider) – A Provider that has signed a contract with the Claims Administrator to participate in the Preferred Care PPO Network. This Provider is also referred to as PPO Providers, Preferred Providers, or Network Providers.
- B. Participating Provider – A Provider that has a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan for other than a Preferred Care or PPO Provider Network.
- C. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator 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.

Quality Blue Provider – Any Provider who has signed a contract to participate in the Quality Blue program. Currently, Quality Blue Providers include family practitioners, general practitioners, pediatricians, internists, geriatricians, nurse practitioners and physician assistants, but more Providers may contract to participate in the Quality Blue program. To verify if a Provider participates in the Quality Blue program, the Plan Participant may review a Provider directory on the Claims Administrator's website at www.bcbsla.com or contact the customer service department at the number on the ID card.

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 Services – 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 24-hour, non-acute care treatment setting to actively treat 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 the Claims Administrator), 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 (1) Physician or registered nurse;
- C. 24-hour nursing service by registered nurses or licensed practical nurses; and
- D. Utilization review plans for all patients.

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

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this 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 Plan Participant 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:

- 1. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required;
- 2. Coordination of care is required prior to drug therapy initiation and/or during therapy;
- 3. Unique patient compliance and safety monitoring requirements;
- 4. Unique requirements for handling, shipping and storage; and
- 5. 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 Plan Participant's legal Spouse.

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 the Claims Administrator.

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 the Claims Administrator 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 Joint (TMJ) Disorders – Disorders resulting in pain and/or dysfunction of the temporomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes.

Urgent Care – A sudden, acute and unexpected medical condition that requires timely diagnosis and treatment but does not pose an immediate threat to life or limb. Examples of Urgent Care include, but are not limited to, colds and flu, sprains, stomach aches and nausea. Urgent Care may be accessed from an Urgent Care Center if a Plan Participant 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 Claims Administrator 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 THAT IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.

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

A. Eligibility

1. Employee. To be eligible to enroll as an Employee, an individual must be:
 - a. an Employee, who is an active, regular Employee of the Employer, who works the required number of hours for coverage, as designated by Employer.
 - b. a retired Employee who satisfies any criteria designated by the Employer, and if shown as covered in the Schedule of Benefits.
 - c. an elected official, officer or director who satisfies any criteria designated by the Employer, and if shown as covered in the 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 Claims Administrator 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 Employee; or
 - (2) legally placed for adoption with the Employee; or
 - (3) legally adopted by the Employee; or
 - (4) a child for whom the Employee or Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Employee or Spouse is a court appointed tutor/tutrix; or
 - (5) a child supported by the Employee pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN). Employees and beneficiaries of this Benefit Plan may obtain, without charge, a description of procedures for QMCSO determinations from the Plan Administrator; or
 - (6) a stepchild of the Employee; or
 - (7) a grandchild residing with the Employee, provided the Employee has been granted legal custody or provisional custody by mandate of the grandchild; or
 - (8) the Employee's child or grandchild who is in the legal custody of and residing with the Employee, who is covered on the plan before turning age twenty-six (26) and is able to remain covered on

the plan once turning age twenty-six (26) because he meets the definition and requirements of an Over-Age Dependent.

B. Enrollment for Coverage

1. Every Eligible Person may enroll for coverage under this Benefit Plan and may include any eligible Dependents.
2. The Plan Administrator will submit all enrollment information to the Claims Administrator as a prerequisite to coverage under this Benefit Plan.
3. No person will be covered under this Benefit Plan unless the Plan Administrator has accepted the enrollment form or enrollment information in a format acceptable to the Claims Administrator and has issued the ID card or other written notice of acceptance. Payment of contributions for any person will not effectuate coverage unless and until the ID card or other written acceptance has been issued, and in the absence of such issuance, liability will be limited to refund of the premiums paid.
4. This Group Benefit Plan and coverage under it will not be issued or renewed unless the percentage of Eligible Persons specified in the Application for Group Coverage is enrolled.
5. If the Group covers retirees, retirees must be enrolled in the Benefit Plan prior to retirement in order to retain coverage under this Benefit Plan. There will be no future right to enroll other than those special enrollment rights in the Benefit Plan that are specific to retirees.

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 Plan Administrator as shown on the Application for Group Coverage. The Plan Administrator has the right to change the classes of coverage selected when needed by sending a request to change classes to the Claims Administrator's underwriting department.

1. Employee only coverage means coverage for the Employee only.
2. Employee and Spouse coverage means coverage for the Employee and Spouse.
3. Employee and Family coverage means coverage for the Employee, Spouse, and one or more Dependent children.
4. Employee and Child (or Children) coverage means coverage for the Employee and one or more Dependent children.
5. Employee and Dependent coverage means coverage for the Employee and one Dependent.

D. Effective Date

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

3. If an Eligible Person's enrollment form for coverage for self or for self and any eligible Dependent(s) is not received by the Claims Administrator 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 an Employee holding coverage which includes Dependent children (Employee and Family coverage or Employee and Child(ren) coverage), and the enrollment form is received by the Claims Administrator 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, if not already enrolled, and enroll the eligible Dependent by completing an enrollment form and submitting the enrollment form to the Claims Administrator 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 elected officials, officers or directors and their Dependents. These rights are not available to retirees.

Individuals who lose other coverage because they do not pay their required contributions or lose other coverage for cause (such as filing fraudulent Claims or an intentional misrepresentation of a material fact in connection with the Benefit 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;
- 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's 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 or contributions 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;
 - (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 an 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 the Claims Administrator 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 the Claims Administrator receives the request for special enrollment. Coverage will not be available if the Claims Administrator 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) they 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 Benefit Plan no later than sixty (60) days after either the date of coverage termination under Medicaid or CHIP or the date the Employee or Dependent is determined to be eligible for such premium assistance. A request for special enrollment under this section must be received by the Claims Administrator within the sixty (60) day period following loss of coverage or the date the Employee or Dependent is determined to be eligible for premium assistance. When special enrollment under this section is made timely and received by the Claims Administrator timely, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP, or the date the Employee or Dependent is eligible for premium assistance.
- b. An Employee may disenroll a Dependent child 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. The Employee must promptly notify the Claims Administrator in writing of the child's disenrollment to avoid continued coverage under this Benefit 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, elected official, officer or director may be enrolled in the plan. If not already participating, a current Employee, elected official, officer or director 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 enroll in the plan for this reason.

- b. A person becomes a Dependent of the covered or eligible Employee, retiree, elected official, officer or director 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, elected official, officer or director may be enrolled as a Dependent if otherwise eligible for coverage.
- c. If the Plan Administrator offers multiple health plan options, another option may be chosen by the current Employee, retiree, elected official, officer or director for himself and Dependents when Special Enrollee status applies.
- d. 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.
- e. In the case of a birth, adoption, or placement for adoption, a current Employee may enroll and enroll the Spouse and/or the newborn/adopted child and any 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 signed enrollment form is received by the Claims Administrator 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. An Employee may enroll an unborn 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.

If the signed enrollment form is not received by the Claims Administrator 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 the request for special enrollment is received. 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 the Claims Administrator does not receive the enrollment form within sixty (60) days of birth, adoption, or placement for adoption.

- f. In the case of marriage, a current Employee may enroll and enroll 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 the Claims Administrator within thirty (30) days of the marriage. If the enrollment form is not received 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 the request for special enrollment is received.

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 the Claims Administrator does not receive the enrollment form within sixty (60) days of marriage.

- g. For Plan Participants holding Employee and Family coverage or Employee 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 Employee'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 Employee's home had he not been ill, to the custody of the Employee or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to an Employee holding coverage which includes Dependent children, the Effective Date of coverage of the adopted Newly Born Infant will be the date of placement into the Employee's home or the date of the custody order. The child's coverage will not be effective from birth. The Plan Participant must notify the Claims Administrator within one hundred eighty (180) days of the date of placement in the home or of the custody order to update Our records.

- 4. In all Special Enrollee circumstances, an Employee, retiree, elected official, officer or director must be enrolled in this Benefit Plan in order for any Dependent(s) to be enrolled.

ARTICLE IV.

BENEFITS

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

A. Benefit Categories

1. If this Benefit Plan includes more than one (1) Plan Participant, the Individual Deductible Amount is not applicable. Only the Family Deductible Amount applies. No Benefits are eligible for payment on any member of the family until the total Family Deductible Amount has been met.
2. If this Benefit Plan includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. Only the Family Out-of-Pocket Amount applies.
3. Network and Non-Network Benefit categories may each carry separate Deductible Amounts and Out-of-Pocket Amounts shown on the Schedule of Benefits.

B. Deductible Amounts and Coinsurance

1. Subject to the Deductible Amount shown on the Schedule of Benefits, the maximum limitations hereinafter provided, and other terms and provisions of this Benefit Plan, the plan will provide Benefits in accordance with the Coinsurance shown on the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period.
 - a. Individual Deductible Amount: The dollar amount shown on the Schedule of Benefits of Allowable Charges for Covered Services, which a Plan Participant with Employee only coverage must pay within a Benefit Period before the Benefit Plan starts paying Benefits.
 - b. Family Deductible Amount: The dollar amount 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 Benefit Plan starts paying Benefits. No Benefits are eligible for payment on any covered member of the family until the total Family Deductible Amount has been met. After the Family Deductible Amount is met, the Benefit Plan starts paying Benefits for all covered members of the family, for the remainder of the Benefit Period. For purposes of this Benefit Plan, family includes all Available Classes of Coverage, except Employee only coverage.
2. The Coinsurance is shown on the Schedule of Benefits for a Covered Service. The Plan Participant must first pay any applicable Deductible Amount before the Coinsurance applies. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Benefit Plan will provide Benefits in the Coinsurance shown on the Schedule of Benefits toward Allowable Charges for Covered Services. The actual payment to a Provider or payment to the Plan Participant satisfies the Plan Sponsor's obligation to provide Benefits under this Benefit Plan.
3. Claims will be applied to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed. The Claims Administrator's system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays the Deductible Amount, the Plan Participant is entitled to receive a refund from the Provider to which the overpayment was made.
4. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are the Plan Participant's responsibility, such as Deductible Amount or Coinsurance, the Claims Administrator may collect such amounts directly from the Plan Participant. The Plan Participant agrees that the Claims Administrator has the right to collect such amounts from the Plan Participant.

C. Out-of-Pocket Amounts

1. Individual Out-of-Pocket Amount: The maximum amount 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 Plan Participant with Employee only coverage, within a Benefit Period. After the Individual Out-of-Pocket is met, the Benefit 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 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 includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. Only the Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount is met, the Benefit 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.
3. The following accrue to the Out-of-Pocket Amount:
 - a. Deductible Amounts; and
 - b. Coinsurance.
4. The following do not accrue to the Out-of-Pocket Amount:
 - a. any charges in excess of the Allowable Charge;
 - b. any penalties the Plan Participant or Provider must pay;
 - c. charges for non-Covered Services; and
 - d. any other amounts paid by the Plan Participant other than Deductible Amount and Coinsurance.

D. Accumulator Transfers

Plan Participants' 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 Plan Participant'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 disorders Admissions) must be Authorized as outlined in the Care Management Article of this Benefit Plan. In addition, at regular intervals during the Inpatient stay, the Claims Administrator will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care. The Plan Participant must pay any Deductible Amount and any Coinsurance shown on the Schedule of Benefits.

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

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Plan Participant requiring an intensive level of care.

3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by the Claims Administrator.
4. In a Residential Treatment Center for Plan Participants with a Mental Health and/or a substance use disorder.

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 Plan Participant must pay any applicable Deductible Amounts 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 are defined and determined by the Claims Administrator and is that period of time which is appropriate as routine care for the particular surgical procedure.
 - b. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.
2. Multiple 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 the Claims Administrator.
 - (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 the Claims Administrator. 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 the Claims Administrator.
- (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 and surgical service performed. The unbundled services are considered included in the proper comprehensive service code as determined by the Claims Administrator.
- (2) The Allowable Charge of the comprehensive service code includes the charge for the unbundled services. The plan will provide Benefits according to the proper comprehensive service code, as determined by the Claims Administrator.

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 the Claims Administrator. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.

- b. Anesthetic or sedation procedures performed by the operating Physician, an assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless the Claims Administrator determines otherwise.
- c. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

5. Second Surgical Opinion

Benefits are available for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. The Physician that provides a second or third opinion must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory 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.

D. Expanded Medical and Surgical Benefits

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

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

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

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

- B. Some pharmacies have contracted with the Claims Administrator or with the Claims Administrator's Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are Participating Pharmacies. Benefits are based on the Allowable Charge as determined by the Claims Administrator. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is based on the amount the Claims Administrator pays its Pharmacy Benefit Manager. The Claims Administrator uses the amount paid to its Pharmacy Benefit Manager to base the plan's payment for the Plan Participant's covered Prescription Drugs and the amount that the Plan Participant must pay for covered Prescription Drugs. To obtain contact information for Participating Pharmacies, the Plan Participant should contact Our customer service department or the Pharmacy Benefit Manager at the telephone number on the ID card.
- C. The Plan Participant 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 Plan Participant has not met the 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 Plan Participant has met the Deductible Amount, the Plan Participant will pay the Coinsurance shown on the Schedule of Benefits. The Participating Pharmacy will electronically submit the Claim for the Plan Participant.
- D. Prescription Drug Formulary

This Benefit Plan covers Prescription Drugs and uses either an open or closed Prescription Drug Formulary. Refer to the Schedule of Benefits to see which Prescription Drug Formulary applies. 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 the Plan Participant less than drugs on higher tiers. For covered drugs that are listed on the formulary, the Claims Administrator's Drug Utilization Management Program, more fully described in the section below, may apply.

Information about the formulary is available in several ways. Most Plan Participants receive information by accessing the pharmacy section of Our website, www.bcbsla.com/pharmacy or request a copy by mail by calling the Pharmacy Benefit Manager at the telephone number indicated on the ID card.

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

1. Open Prescription Drug Formulary

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

The Plan Participant may file a written Appeal to the Claims Administrator if a Prescription Drug is not included in the formulary and the prescribing healthcare Provider has determined that the drug is Medically Necessary for the Plan Participant. Instructions for filing an Appeal are included in this Benefit Plan.

Open Formulary – (Two Tier)

After the Deductible Amount has been met, Benefits for Prescription Drugs dispensed at a retail pharmacy 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.

- 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 the Claims Administrator's Prescription Drug Formulary, there is a drug review process. This process allows the Plan Participant's prescribing healthcare Provider to ask for a drug review from the Claims Administrator. This request must be based on Medical Necessity. If the request is approved, the Plan Participant will receive coverage for the drug that is not on the Prescription Drug Formulary. If the request is not approved, the Plan Participant may file an internal or external drug review request to the Claims Administrator.

Closed Formulary – (Two Tier)

- a. After the applicable Deductible Amount has been met, Benefits for Prescription Drugs dispensed at a retail pharmacy 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.
 - (1) Tier 1: Generic Drugs
 - (2) Tier 2: Brand-Name Drugs
- b. If a drug review request is approved, the Plan Participant 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.

E. Drug Utilization Management Program

The Claims Administrator's Drug Utilization Management Program features a set of closely aligned programs that are designed to promote Plan Participant safety, appropriate and cost-effective use of medications, and monitor healthcare quality.

Examples of these programs include:

1. Prior Authorization – As part of the Claims Administrator's Drug Utilization Management program, Plan Participants and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on the Claims Administrator's website at www.bcbsla.com/pharmacy or by calling the customer service telephone number on the ID card. If the Prescription Drug requires prior Authorization, the Plan Participant'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 Plan Participant's prescription is filled, the Claims Administrator's Pharmacy Benefit Manager or the Claims Administrator 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 the Claims Administrator are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity Per Dispensing Limits/Allowances are based on the following: (a) the manufacturer's recommended dosage and duration of therapy; (b) common usage for episodic or intermittent treatment; (c) FDA-approved recommendations and/or clinical studies; or (d) as determined by the Claims Administrator.
4. Step Therapy – Certain drugs and/or drug classes are subject to Step Therapy. In some cases, the Plan Participant may be required to first try one or more Prescription Drugs to treat a medical condition before the Claims Administrator will cover another Prescription Drug for that condition. For example, if Drug A

and Drug B both treat the Plan Participant's medical condition, the Claims Administrator may require the Plan Participant's Physician to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Claims Administrator will cover a prescription written for Drug B. However, if the Plan Participant's Physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if the Plan Participant chooses a Step B drug included in the Step Therapy program without first trying a Step A alternative, the Plan Participant will be responsible for the full cost of the drug.

5. Step Therapy Overrides – The Plan Participant's 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, the Claims Administrator will respond to the request within seventy-two (72) hours unless exigent circumstances exist, in which case the Claims Administrator will respond to the request within twenty-four (24) hours. If the Claims Administrator does 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 Benefit.

G. When a Plan Participant purchases covered Prescription Drugs from a pharmacy that has not contracted with the Claims Administrator or with its Pharmacy Benefit Manager or when a Plan Participant files a paper Claim with the Claims Administrator or with its Pharmacy Benefit Manager, the Allowable Charge is the amount that the Claims Administrator pays its 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 Plan Participant should submit Claims on the Prescription Drug Claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Plan Participant should contact the Claims Administrator or its Pharmacy Benefit Manager at the telephone number indicated on the ID card.

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

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

K. Specialty Pharmacy Program

The Specialty Pharmacy Program covers certain drugs commonly referred to as high-cost Specialty Drugs. The Claims Administrator contracts with a specialty pharmacy to dispense and deliver covered Specialty Drugs. Plan Participants are required to use a contracted specialty pharmacy to obtain Specialty Drugs. A contracted specialty pharmacy may provide special handling and additional helpful services such as courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and educational programs focused on the disease for which the medication is dispensed. Examples of common diseases that are treated with Specialty Drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis. To obtain information about a contracted specialty pharmacy, the Plan Participant should contact the Claims Administrator, or the Pharmacy Benefit Manager at the telephone number indicated on the ID card or refer to the Schedule of Benefits.

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to a Plan Participant. If a Plan Participant 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 Plan Participant receives Covered Services for Preventive or Wellness Care from a Non-Network Provider, Benefits will be subject to Coinsurance shown on the Schedule of Benefits. The Deductible Amount will not apply to Covered Services received for Preventive or Wellness Care. Preventive or Wellness Care services may be subject to other limitations shown on the Schedule of Benefits.

A. Well Woman Examinations

1. Routine visits to Network Providers for obstetrical or gynecological care. Additional visits to a Provider for obstetrical, gynecological care 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 the Plan Participant when obtained from a Network Provider.
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 Benefits for High-Tech Imaging Services when Medically Necessary.

B. Physical Examinations

1. Routine Wellness Physical Exam. Certain routine wellness diagnostic tests ordered by the Plan Participant's 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 may be covered under standard 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.

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 Plan Participant's Physician.

D. Colorectal Cancer Screenings

Benefits are available for routine colorectal cancer screenings provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by the Claims Administrator to be Investigational. If the following Covered Services for colorectal cancer screening are rendered by a Network Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge.

1. Fecal Immunochemical Test (FIT) for blood (1 per Benefit Period for ages 45-75)
2. One (1) Cologuard (FIT-fecal) DNA Testing (1 per Benefit Period for ages 45-75)
3. One (1) Computed Tomographic (CT) Colonography (1 every 5 years for ages 45-75)
4. One (1) Flexible Sigmoidoscopy (1 every 5 years for ages 45 -75)
5. One (1) Colonoscopy (1 every 10 years for ages 45-75)

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

E. Other Wellness Services

1. One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, is covered for Plan Participants fifty (50) years of age or older, and as recommended by his Physician if the Plan Participant is over forty (40) years of age. A second visit shall be permitted if recommended by the Plan Participant's Physician for follow-up treatment within sixty (60) days after the visit, if related to a condition diagnosed or treated during the visit.
2. Intensive behavioral counseling for an obesity diagnosis is covered for Plan Participants ages three (3) through eighteen (18). Benefits are limited to fifty-two (52) visits per lifetime for children prior to age nineteen (19) at no cost to the Plan Participant when services are rendered by a Network Provider. Visits exceeding fifty-two (52) prior to age nineteen (19) will be paid subject to standard Benefits. Adults are limited to twenty-four (24) intensive behavioral counseling visits for obesity per Benefit Period at no cost to Plan Participant when using a Network Provider. Visits exceeding twenty-four (24) will be paid subject to standard Benefits. Services not rendered by a Network Provider are not covered.

WHAT A PLAN PARTICIPANT PAYS FOR PREVENTIVE OR WELLNESS CARE BENEFITS		
WELLNESS BENEFIT	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Well Woman Exams		
Routine Gynecological or Obstetrical care visits	No Cost	Coinsurance
Routine Pap Smear	No Cost	Coinsurance
Mammograms and Breast Ultrasounds	No Cost	Coinsurance
Breast MRIs	Coinsurance	Coinsurance
Physical Exams		
Routine Physical Exam (including related diagnostic tests)	No Cost	Coinsurance
Well Baby Care	No Cost	Coinsurance
Immunizations		
State-Mandated Immunizations	No Cost	Coinsurance
All Other Recommended by Physician	No Cost	Coinsurance
Colorectal Cancer Screenings		
Fecal Immunochemical Test (FIT) for blood	No Cost	Coinsurance
Flexible Sigmoidoscopy	No Cost	Coinsurance
Colonoscopy	No Cost	Coinsurance
Cologuard (FIT-fecal) DNA Testing	No Cost	Coinsurance
Computed Tomographic (CT) Colonography	No Cost	Coinsurance
Other Wellness Services		
PSA Test	No Cost	Coinsurance

F. Preventive or Wellness Care Services

The list of covered Preventive and Wellness Care services changes from time to time. To check the current list of Covered Services, the Plan Participant may view a copy of the Grandfathered Preventive Care Services brochure by visiting Our website at: www.bcbsla.com/preventive.

ARTICLE IX. MENTAL HEALTH BENEFITS

Benefits for the treatment of Mental Disorder are available. Covered Services will be only those which are for treatment rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for the treatment of Mental Disorders do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and employment counseling. Coverage for Mental Health includes services delivered through the Psychiatric Collaborative Care Model when used to treat a behavioral health diagnosis as approved by the Claims Administrator.

ARTICLE X. SUBSTANCE USE DISORDER BENEFITS

Benefits for the treatment of substance use disorders are available. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Coverage for substance use disorders includes services delivered through the Psychiatric Collaborative Care Model when used to treat a behavioral health diagnosis as approved by the Claims Administrator.

ARTICLE XI. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, Providers in the Preferred Care PPO 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 Plan Participant'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 department 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 (TMJ) Disorders and associated musculature and neurological conditions. Services may require prior Authorization, as shown on the Schedule of Benefits.

ARTICLE XII. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

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

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

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow 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 Blue Cross and Blue Shield of Louisiana Preferred Provider approved facility, unless otherwise approved by the Claims Administrator in writing. To locate an approved transplant facility, Plan Participants 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 the Claims Administrator determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.

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

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

ARTICLE XIII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

Benefits for treatment of ectopic pregnancies and spontaneous abortions (miscarriages) are available for all covered Plan Participants under the Hospital Benefits and Medical and Surgical Benefits Articles of this Benefit Plan.

Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a patient covered as a Plan Participant or Dependent wife of a Plan Participant 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.

The Claims Administrator has several maternity programs available to help pregnant Plan Participants deliver

healthy babies. Please call Our customer service department at the number on the 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 Plan Participant 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 prenatal and postnatal care
 - d. Medically Necessary abortions required in order to save the life of the mother
2. Maternity support services are available when provided by a registered Doula to pregnant and birthing women and their families before, during, and after childbirth. Benefits are limited to \$1500 per pregnancy when services are rendered by a Network Doula and are subject to any applicable Deductible Amount and Coinsurance. Services rendered by a Non-Network Doula are not covered.
3. 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 the Claims Administrator, well newborn charges may be covered if the Plan Participant under this Benefit Plan is the father.
4. 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.
5. The Family Deductible Amount, shown on the Schedule of Benefits, applies to all charges when a newborn is added to a plan of a Plan Participant holding Employee 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 Benefit Plan.

When a child is born to a Plan Participant having Employee only coverage, the child is granted thirty (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.

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

1. Medical and surgical services rendered by a Physician, for treatment of illness, prematurity, postmaturity, 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, prematurity, postmaturity, 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 the Claims Administrator, well newborn charges may be covered if the Plan Participant under this Benefit Plan is the father.
3. The Family Deductible Amount shown on the Schedule of Benefits applies to all charges when a newborn is added to a plan of a Plan Participant holding Employee 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 Benefit Plan.

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

Under federal law, health insurance issuers generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the 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, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an 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 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, 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 Chiropractic Services. Benefits are available when services are rendered by a Provider licensed and practicing within the scope of that license. In order for care to be considered at an Inpatient Rehabilitation facility, the Plan Participant must be able to tolerate a minimum of three (3) hours of active therapy per day.

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

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 the Claims Administrator.

A. Occupational Therapy

1. Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of that 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 that 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 plan of care;
- b. As part of a Home Health Care agency pursuant to the plan of care;
- c. To a patient in a nursing home pursuant to the 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 that 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, speech/language development disorders, cognitive-communication, 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 that 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

Certain Benefits require Authorization if shown on the Schedule of Benefits and the Care Management Article. The Plan Participant must pay any Deductible Amount and Coinsurance shown on the Schedule of Benefits.

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

A. Acupuncture Benefits

Benefits are available for 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 Plan Participants, to the nearest Hospital capable of providing services appropriate to the Plan Participant'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 Plan Participants for non-Emergency medical conditions when Inpatient or Outpatient services are Medically Necessary and the Plan Participant is bed-confined or the Plan Participant's 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 Plan Participant 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 Plan Participant to a facility for further medical care.

3. Air Ambulance Transport Services

a. Emergency Transport

Benefits for air Ambulance Services are available for Plan Participants with an Emergency Medical Condition. The air Ambulance Service must be specifically requested by police or medical authorities present at the site with the Plan Participant in order for air Ambulance Services to be covered.

Benefits for air Ambulance Services are also available for Emergency transport when the Plan Participant 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 Plan Participant'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 the Claims Administrator before services are rendered or no Benefits are available for the services. If Authorized by the Claims Administrator before services are rendered, Benefits for non-Emergency air Ambulance Services are available for Plan Participants to the nearest facility or Hospital capable of providing services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care. Once

Authorized, the Plan Participant 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, 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 Plan Participant pays a periodic fee to an ambulance membership organization with which the Claims Administrator does not have a Provider agreement, Benefits for expenses incurred by the Plan Participant for Ambulance Services will be based on any obligation the Plan Participant must pay that is not covered by the fee.

If there is in effect a Provider agreement between the Claims Administrator and the ambulance organization, Benefits will be based on the Allowable Charge.

- 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 Plan Participant's comfort or convenience.
- d. No Benefits are available when a Hospital transports Plan Participants 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

Autism Spectrum Disorders 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. Plan Participants who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis, when the Claims Administrator determines it is Medically Necessary. Applied Behavior Analysis is not covered for Plan Participants age twenty-one (21) and older.

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

E. Bone Mass Measurement

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

1. An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;
2. An individual receiving long-term steroid therapy; or
3. An individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.

Deductible Amount and/or Coinsurance are applicable.

F. BRCA1 and BRCA2 Genetic Testing

Genetic testing of BRCA1 and BRCA2 genes will be covered 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 for testing.

Deductible Amount and/or Coinsurance are applicable.

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

1. Under the Women's Health and Cancer Rights Act, a Plan Participant 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 a partial or full unilateral 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 must be delivered in a manner determined in consultation with the Plan Participant and the Plan Participant's attending Physician, if applicable, and will be subject to any 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. Plan Participants 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 Plan Participant. Annual preventive cancer screenings under this Benefit are subject to any applicable Deductible Amount and Coinsurance.

H. 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.

I. Clinical Trial Participation

1. This Benefit Plan shall provide coverage for patient costs incurred as a result of a treatment being provided in accordance with a clinical trial for cancer. Coverage will be subject to any applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.
2. The following services are not covered:
 - a. Non-healthcare services provided as part of the clinical trial;
 - b. Costs for managing research data associated with the clinical trial;
 - c. Investigational drugs or devices; and/or
 - d. Services, treatment or supplies not otherwise covered under this Benefit Plan.
3. Investigational treatments and associated protocol-related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:
 - a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or for the prevention or early detection of cancer.
 - b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
 - c. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
 - (1) One of the United States National Institutes of Health.
 - (2) A cooperative Group funded by one of the National Institutes of Health.
 - (3) The FDA in the form of an Investigational new drug application.
 - (4) The United States Department of Veterans Affairs.
 - (5) The United States Department of Defense.
 - (6) A federally funded general clinical research center.
 - (7) The Coalition of National Cancer Cooperative Groups.

- d. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state, and which has a multiple project assurance contract approved by the office of protection from research risks.
- e. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
- f. There must be no clearly superior, non-investigational approach.
- g. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.
- h. The patient has signed an institutional review board approved consent form.

J. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

- a. Plan Participants that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by the Plan Participant's treating Provider.
- b. Evaluation and training programs for diabetes self-management are covered subject to the following:
 - (1) The program must be prescribed by the Plan Participant's treating Provider and provided by a licensed healthcare professional who certifies that the Plan Participant 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 Plan Participants 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 Plan Participant when services are rendered by a Network Provider. Additional screenings or screenings by a Non-Network Provider are covered subject to standard Benefits.

K. Dietitian Visits for Nutritional Counseling

Benefits are available for Outpatient visits to registered dietitians for nutritional counseling. One (1) dietitian visit for nutritional counseling is covered at no cost to Plan Participants when the dietitian is a Network Provider. All other subsequent dietitian visits for nutritional counseling are covered at standard Benefits. Dietitian visits for diabetics are available under a separate Benefit for diabetes education and training for self-management.

L. 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 the Claims Administrator. The equipment and supplies are subject to the Plan Participant's medical Deductible Amount and Coinsurance.

M. 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 Plan Participant 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 Claims Administrator'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 the Claims Administrator, Benefits for standard equipment will be provided toward any deluxe equipment when a Plan Participant 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 Plan Participant's comfort or convenience; or
 - (d) that are not determined by the Claims Administrator 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 due to loss, theft, misuse, abuse, neglect, or destruction is not covered. The Claims Administrator also will not cover replacement in cases where the Plan Participant sells or gives away the equipment. 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 repair or replacement of equipment due to loss, theft, misuse, abuse, neglect, or destruction. There is no coverage for replacement of equipment in cases where the Plan Participant sells or gives away the equipment.
- (4) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by the Claims Administrator.
- (5) Regardless of Claims of Medical Necessity, deluxe equipment or deluxe features and functionalities of equipment that are not approved by the Claims Administrator are not covered.

2. Orthotic Devices

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

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.
- b. Repair or replacement of the Orthotic Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the device. The Claims Administrator 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 the Claims Administrator, Benefits for standard devices will be provided toward any deluxe device when a Plan Participant 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 Plan Participant's comfort or convenience; or
 - (d) that are not determined by the Claims Administrator 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 the Claims Administrator 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 are Authorized by the Claims Administrator and are covered subject to the following:

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance 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 Claims Administrator 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 the Claims Administrator, 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 Plan Participant's comfort or convenience; or
 - (d) that are not determined by the Claims Administrator 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 the Claims Administrator 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 the Claims Administrator Authorizes, 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. The Claims Administrator 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 the Claims Administrator, 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 Plan Participant's comfort or convenience; or
 - (d) that are not determined by the Claims Administrator 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 the Claims Administrator are not covered.
- c. A Plan Participant 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).

N. Fertility Preservation Services

Medically Necessary standard fertility preservation services are covered for a Plan Participant receiving Medically Necessary treatment that will result in Iatrogenic Infertility. Standard fertility preservation services include extraction, cryopreservation, and up to three (3) years of storage of oocytes and sperm. No benefits are available for Prescription Drugs whether offered as a pharmacy Benefit or medical Benefit as part of the standard fertility preservation services.

Benefits for fertility preservation services are subject to a lifetime maximum of \$10,000. If storage costs have been covered for three (3) years, no additional benefits will be provided, even if the \$10,000 lifetime maximum has not been met. This Benefit is subject to payment of any applicable Deductible Amount and Coinsurance which will apply to the \$10,000 lifetime maximum.

O. 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 CLAIMS ADMINISTRATOR PRIOR TO SERVICES BEING PERFORMED; AND
2. WHEN SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM THE CLAIMS ADMINISTRATOR TO PERFORM THE PROCEDURE.

P. Genetic or Molecular Testing for Cancer

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

Q. Hearing Aid Benefits

1. Benefits are available for hearing aids for covered Plan Participants age 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 licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.
2. Benefits are available for cochlear implants and bone-anchored hearing aids (BAHA) for all eligible Plan Participants 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 any applicable Deductible Amount and Coinsurance .

R. 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. The Claims Administrator must Authorize these services before the Plan Participant receives them.

S. Home Health Care

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

T. Hospice Care

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

U. Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter or transliterator are covered when the Plan Participant needs such services in connection with medical treatment or diagnostic Consultations performed by a Physician or Allied Health Professional, if the services are required because of hearing loss or 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.

V. 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:

1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)
5. Propionic Acidemia
6. Glutaric Acidemia
7. Urea Cycle Defects
8. Tyrosinemia

W. 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.

X. Permanent Sterilization Procedures

Benefits are available for surgical procedures that result in permanent sterilization, including tubal ligation, vasectomy, and hysteroscopic placement of micro-inserts into the fallopian tubes.

Y. Contraceptive Devices (Non-Permanent Sterilization)

Benefits are available for contraceptive intrauterine devices (IUDs), including the insertion and removal of such devices.

Z. 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 the Claims Administrator.

AA. Prescription Drugs

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

BB. Private Duty Nursing Services

1. Coverage is available to a Plan Participant for Private Duty Nursing Services when performed on an Outpatient basis and when the RN or LPN is not related to the Plan Participant 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.

CC. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage.

DD. Telehealth Services and Remote Patient Therapy Services

Benefits are available to Plan Participants for the diagnosis, consultation, treatment, education, care management, patient self-management, and caregiver support when the Plan Participant and the Provider are not physically located in the same place.

Interaction between the Plan Participant and the 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 the Claims Administrator 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 the Claims Administrator.

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 the Claims Administrator.

In order to be covered, Remote Patient Therapy Services must specifically be required for medical treatment decisions for the Plan Participant 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 the Plan Participant pays for a Telehealth Services or Remote Patient Therapy Services visit may be different than the amount the Plan Participant would pay for the same Provider's service in a non-Telehealth or non-Remote Patient Therapy setting. The Plan Participant will pay more for a Telehealth visit or a Remote Patient Therapy visit when your Provider is not in the Network.

The Claims Administrator has the right to determine if billing was appropriate and contains the required elements 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 the Claims Administrator.

EE. Temporomandibular Joint (TMJ) Disorders

Benefits are available to the Plan Participant for the diagnosis, therapeutic, or surgical procedures related to Temporomandibular Joint (TMJ) Disorders and associated musculature and neurological conditions. Services may require prior Authorization, as shown on the Schedule of Benefits.

ARTICLE XVI. CARE MANAGEMENT

For a list of items and services that require Authorization, visit Our website, www.bcbsla.com/priorauth.

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. Participating and Non-Participating Providers are Non-Network Providers.

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

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

- b. If the Claims Administrator does approve the use of a Non-Network Provider, that Provider may or may not accept the Plan Participant's Deductible Amount and Coinsurance at the time services are rendered. The Claims Administrator will pay Benefits up to the Allowable Charge for Covered Services rendered by an approved Non-Network Provider who has obtained any required Authorizations prior to services being rendered. The Claims Administrator will deduct from the payment the amount of the Plan Participant'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 a required Authorization is not requested prior to the Admission or receiving other Covered Services and supplies requiring an Authorization, the Claims Administrator has the right to determine if the Admission or other Covered Services and supplies were Medically Necessary.

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

If the Admission or other Covered Services 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, the Claims Administrator will reduce Allowable Charges by the penalty stipulated in the Provider's contract with the Claims Administrator or with another Blue Cross and Blue Shield plan. The Network Provider or Participating Provider is responsible for all charges not covered. The Plan Participant 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, the Claims Administrator will reduce Allowable Charges by the penalty if shown on the Schedule of Benefits. The Plan Participant is responsible for all charges not covered and for any applicable penalty, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

b. Outpatient Services, Including Other Covered Services and Supplies

- (1) If a Network Provider fails to obtain a required Authorization, the Claims Administrator may reduce the Allowable Charge by the penalty stipulated in the Provider's contract. This penalty applies to all Outpatient services and supplies requiring an Authorization. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Deductible Amount and 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 Plan Participant is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.
- (3) If a service or supply was not Medically Necessary, the service or supply is not covered.
- (4) If a Provider fails to obtain a required Authorization for the Outpatient services and supplies which indicate no Benefit without written / prior Authorization on the prior Authorization list, the Outpatient services and supplies are not covered.

3. Authorization of Admissions

a. Authorization of Elective Admissions

The Plan Participant is responsible for ensuring that the Provider notifies the Claims Administrator's care management department of any Elective or non-Emergency Inpatient Hospital Admission. The Claims Administrator 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 the Claims Administrator prior to the Admission, the Provider should contact the care management department at the telephone number shown on the Schedule of Benefits, the customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or facility. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Claims Administrator when the Hospital Inpatient setting is documented to be Medically Necessary.

- (1) If a request for prior Authorization is denied, the Admission is not covered and the Plan Participant must pay all charges incurred during the Admission.
- (2) If Authorization is not requested prior to an Admission, the Claims Administrator has the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.
- (3) Additional amounts for which the Plan Participant is responsible because Authorization of an Elective or non-Emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

It is the Plan Participant's responsibility to ensure that the Physician or Hospital, or a representative thereof, notifies the Claims Administrator's care management department of all Emergency Admissions. Within forty-eight (48) hours of the Emergency Admission, the Claims Administrator must be notified regarding the nature and purpose of the Emergency Admission. The facility or Provider should contact the care management department at the telephone number shown on the Schedule of Benefits, the customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or facility. The Claims Administrator may waive or extend this time limitation if the Claims Administrator determines that the Plan Participant is unable to timely notify or direct a representative to notify the Claims Administrator of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend, the Claims Administrator must be notified on the next working day.

The appropriate length of stay for the Emergency Admission will be determined by the Claims Administrator when the Hospital Inpatient setting is documented to be Medically Necessary.

- (1) If Authorization is denied, the Admission will not be covered, and the Plan Participant must pay all charges incurred during the Admission.
- (2) If Authorization is not requested, the Claims Administrator has the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.
- (3) Additional amounts for which the Plan Participant is responsible because Authorization of an Emergency Admission was denied or not requested are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

c. Concurrent Review

When the Claims Administrator Authorizes a Plan Participant's Inpatient stay, the Claims Administrator will Authorize the stay in the Hospital for a certain number of days. If the Plan Participant

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

- (1) If the Claims Administrator does not receive a request for Authorization for continued stay on or before the Plan Participant's last Authorized day, no days are approved past the last Authorized day, and no additional Benefits will be paid unless the Claims Administrator receives and Authorizes another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and the Claims Administrator determines that it is not Medically Necessary for the Plan Participant to receive continued hospitalization or hospitalization at the level of care requested, the Claims Administrator will notify the Plan Participant and Providers, in writing, that the request is denied and no additional days are Authorized.
- (2) If the Claims Administrator denies a Concurrent Review request or level of care request for Hospital Services, the Claims Administrator will notify the Plan Participant, the Physician and the Hospital of the denial. If the Plan Participant elects to remain in the Hospital as an Inpatient thereafter, or at the same level of care, the Plan Participant will not be responsible for any charges unless the Plan Participant is notified of the financial responsibility by the Physician or Hospital in advance of incurring additional charges.
- (3) Charges for non-Authorized days in the Hospital that the Plan Participant must pay are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

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

Certain services, supplies, and Prescription Drugs require Authorization before a Plan Participant receives the services, supplies, or Prescription Drugs. The Authorizations list is shown on the Plan Participant's Schedule of Benefits. The Plan Participant is responsible for making sure the Provider obtains all required prior Authorizations before the services, supplies, or Prescription Drugs are received. The Claims Administrator may need the Plan Participant's Provider to submit medical or clinical information about the Plan Participant's condition. To obtain prior Authorizations, the Plan Participant's Provider should contact the care management department at the telephone number shown on the Schedule of Benefits, the customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or facility.

- a. If a request for Authorization is denied by the Claims Administrator, the Outpatient services and supplies are not covered.
- b. If a Provider fails to obtain Authorization for the Outpatient services and supplies which indicate no Benefit without written / prior Authorization on the prior Authorization list, the Outpatient services and supplies are not covered.
- c. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, the Claims Administrator has 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.
- d. Additional amounts for which the Plan Participant is responsible because Authorization of Outpatient services and supplies was denied or not requested are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

5. Cancer Patient's Right to Prompt Coverage Act

The requirements set forth in La. R.S. 22:1016.12 through La. R.S. 22:1016.16, the Cancer Patient's Right to Prompt Coverage Act related to prior authorization (as defined therein) and coverage of services for the diagnoses and treatment of cancer will be followed.

6. Utilization Review Standards Required by Louisiana Law

The requirements set forth in La. R.S. 22:1260.41 through La. R.S. 22:1260.48 related to utilization review, including to prior authorization (as defined therein), will be followed.

B. Disease Management

1. Qualification – The Plan Participant may qualify for Disease Management programs, at the Plan's discretion, based on various criteria, including a diagnosis of chronic illness, severity, and proposed or rendered treatment. The program seeks to identify candidates as early as possible. Self-management techniques are reinforced, and a personal nurse is assigned. The Plan Participant, Physicians and caregivers may be included in all phases of the disease management program. The disease management nurse may also refer Plan Participants to community resources for further support and management.
2. Disease Management Program – Blue Cross and Blue Shield of Louisiana's Disease Management programs are committed to improving the quality of care for Plan Participants as well as decreasing healthcare costs in populations with a chronic disease. The nurse works with Plan Participants to help them learn the self-care techniques they will need in order to manage their chronic disease, establish realistic goals for lifestyle modification, and improve adherence to their Physician prescribed treatment plan. Blue Cross and Blue Shield of Louisiana is dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant.

C. Case Management

1. The Plan Participant may qualify for Case Management Services based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.
2. The role of Case Management is to service the Plan Participant by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who Benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.
3. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Case Management services will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant. The provision of Case Management services to one Plan Participant will not entitle any other Plan Participant to Case Management services or be construed as a waiver of the Claims Administrator's right to administer and enforce this Benefit Plan in accordance with its express terms.
4. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Benefit Plan, including but not limited to maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Case Management services.
5. The Plan Participant's Case Management services will be terminated upon any of the following occurrences:
 - a. The Claims Administrator determines that a Plan Participant is no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.
 - b. The short and long-term goals established in the Case Management plan have been achieved, or the Plan Participant elects not to participate in the Case Management plan.

D. Alternative Benefits

1. The Plan Participant may qualify for Alternative Benefits, at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Plan Participant and to the Group.
2. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Alternative Benefits will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant; nor will the provision of Alternative Benefits to a Plan Participant entitle any other Plan Participant to Alternative Benefits or be construed as a waiver of the Claims Administrator's right to administer and enforce this Benefit Plan in accordance with its express terms.
3. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Alternative Benefits.
4. Alternative Benefits are provided in lieu of the Benefits to which the Plan Participant is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Benefit Plan.
5. The Plan Participant's Alternative Benefits will be terminated upon any of the following occurrences:
 - a. The Claims Administrator determines, in their sole discretion, that the Plan Participant is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.
 - b. The Plan Participant receives care, treatment, services, or supplies that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by the Claims Administrator.

ARTICLE XVII. LIMITATIONS AND EXCLUSIONS

- A. Benefits for conditions, services, Surgery, supplies and treatment that are not covered under this Benefit Plan are excluded.
- B. If a Plan Participant has Complications from excluded conditions, Surgery, or treatments; Benefits for such conditions, services, Surgery, supplies and treatment are excluded.
- C. **ANY LIMITATION OR EXCLUSION LISTED IN THIS BENEFIT PLAN MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.**
- 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 Plan Participant has no obligation to pay, or for which no charge or a lesser charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions;
- b. rendered or furnished before the Plan Participant's Effective Date;
- c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his/her license;
- d. paid or payable under Medicare Parts A or B when a Plan Participant has Medicare, except when Medicare Secondary Payer provisions apply;
- e. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with the Claims Administrator's policies and procedures;
- f. 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 Plan Participant holding ten (10%) percent or more ownership in the Group, if the Plan Participant 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 the Group's workers' compensation carrier electing not to be covered by such coverage; (2) properly enrolled with the Company in owner 24-hour health coverage; (3) furnished the Company with a copy of the written agreement between the Plan Participant and the workers' compensation carrier; (4) furnished the Company with written evidence of the Plan Participant's ownership interest in the Group. If this information is not submitted to the Company at the time of the Plan Participant's initial enrollment for health coverage, or upon acquisition of the required ownership percentage, then the Plan Participant may enroll for this coverage at Plan Participant's next Open Enrollment Period;
- g. 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;
- h. rendered, prescribed, or otherwise provided by a Provider who is the Plan Participant, the Plan Participant's Spouse, child, stepchild, parent, stepparent or grandparent;
- i. for telephone calls, video communication, text messaging, e-mail messaging, instant messaging, or patient portal communications between the Plan Participant and the 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 the Claims Administrator; and for Telehealth Services rendered by Providers not permitted by the Claims Administrator;
- j. for Remote Patient Therapy Services and devices unless the results are specifically required for a medical treatment decision for a Plan Participant or as required by law;
- k. for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider;
- l. for services performed in the home unless the services meet the definition of Home Health Care, or otherwise covered specifically in this Benefit Plan, or are approved by the Claims Administrator;
- 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 Plan Participant's commission or attempted commission of a felony;
 - e. for treatment of any Plan Participant 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. When a Medically Necessary mastectomy is otherwise covered under this Benefit Plan, removal of breast implants that were originally implanted during a Cosmetic Surgery and/or for cosmetic purposes is only covered when removal constitutes an incidental service under the Medical and Surgical Benefits Article of this Benefit Plan. As an incidental service, the removal of breast implants, capsulectomy, and other services, treatments, or procedures determined by the Claims Administrator to be an incidental service may not be billed separately;
 - 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 or habit changing clinics or programs except those the law requires the plan to cover or those the Claims Administrator offers, endorses, approves, or promotes as a part of the Plan Participant's healthcare coverage under this Benefit Plan. The Claims Administrator may also offer services as a Value-Added Services subject to minimal additional cost. If clinically eligible to participate, the Plan Participant voluntarily chooses whether to participate in the programs.
 - j. diabetes prevention programs unless approved by the Claims Administrator and limited to once every thirty-six (36) months;

- k. wilderness camp/programs except when provided by a qualified Residential Treatment Center and approved by the Claims Administrator as Medically Necessary for the treatment of Mental Health conditions or substance use disorders;
 - l. treatment related to erectile or sexual dysfunctions, low sexual desire disorder or other sexual inadequacies;
 - 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;
 - 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 shown in the Diabetes Benefits section), eyeglasses or contact lenses or exams (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 Plan Participant is a donor except as provided in this Benefit Plan;
 - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;
 - c. the transplant of any non-human organ or tissue; or
 - d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.
9. **REGARDLESS OF 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 Claims Administrator 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.
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. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for implantable contraceptive devices that do not result in permanent sterilization, except for covered intrauterine devices (IUDs).
13. Benefits are excluded for Prescription Drugs that the Claims Administrator determines are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered 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 the Claims Administrator 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 (2) 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 the Claims Administrator;
 - e. fertility drugs;
 - f. nutritional or dietary supplements, or herbal supplements and treatments. 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 (1) active ingredient (sometimes called 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 Plan Participant's Effective Date or after a Plan Participant'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 or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®); low sexual desire disorder (Addyi®) or other sexual inadequacies;
- u. 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;
- v. 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;
- w. Prescription Drugs for and/or treatment of idiopathic short stature;

- x. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Plan Participant misrepresentation to that prescriber. Limitation may include, but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy;
 - y. topically applied prescription drug preparations that are approved by the FDA as medical devices;
 - z. Prescription Drugs subject to the Step Therapy program when the Step Therapy program was not utilized, or the drug was not approved by the Claims Administrator or the Claims Administrator's Pharmacy Benefit Manager;
 - aa. 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 the Claims Administrator's Pharmacy Benefit Manager;
 - bb. 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 Claims Administrator are covered under the medical Benefit and excluded under the pharmacy Benefit; and
 - cc. sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Plan Participant's Coinsurance and the Claims Administrator's financial responsibility.
14. **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 Plan Participant's home or vehicle.
 15. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for routine foot care; palliative or cosmetic care or treatment of the foot; and treatment of flat feet, except for Medically Necessary Surgery. Additionally, Benefits for cutting or removal of corns and calluses, nail trimming or debriding, or supportive devices of the foot are available for persons who have been diagnosed with diabetes when those services are Medically Necessary.
 16. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any abortions 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. This exclusion shall not apply to services covered under the Fertility Preservation Services section of this plan.
 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. This exclusion shall not apply to services covered under the Fertility Preservation Services section of this plan.
 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 Hospital, medical or Surgical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.
21. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.
22. **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.
23. **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.
24. **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.
25. **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.
26. **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.
27. **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 the Plan Participant's condition, except as specifically provided in this Benefit Plan, or as approved by the Claims Administrator.
28. **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. Plan Participants traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to the Plan Participant's home country and air/sea travel when ambulance is not required.
29. **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 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.
30. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Applied Behavior Analysis that the Claims Administrator determines is not Medically Necessary. The following is also excluded: Applied Behavior Analysis rendered to Plan Participants age twenty-one (21) and older; 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.

31. **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's office.
32. **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.
33. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Hospital charges for a well newborn, except as specifically provided in this Benefit Plan.
34. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for counseling services including, but not limited to, career counseling, marriage counseling, divorce 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.
35. **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).
36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for reversal of a voluntary sterilization procedure.
37. **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 the Claims Administrator. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by the Claims Administrator.
38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a covered Plan Participant related to:
 - a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or as required by law;
 - b. Pre-implantation genetic diagnosis;
 - c. Preconception carrier screening; and
 - d. Prenatal carrier screening except screenings for cystic fibrosis.
39. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services or supplies for the prophylactic storage of cord blood.
40. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for Mental Health services or substance use disorder services delivered through the Psychiatric Collaborative Care Model when used to treat a condition other than an approved behavioral health diagnosis.
41. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Virtual reality services, supplies, technologies, treatment, devices, or expenses related thereto no matter the setting in which virtual reality is used, including, but not limited to, Surgery.

ARTICLE XVIII. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

1. If eligibility for Group coverage ceases upon the death of the Plan Participant, 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 Plan

Participant's death to notify the Claims Administrator of election to continue the same coverage, and if already covered, for any Dependents.

- a. Coverage is automatic during the ninety (90) day election period. Contributions must be paid for this coverage. If continuation is not chosen, or if contributions are 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.
 - b. If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Contributions are owed from the last date for which contributions have been paid. No physical exams are required. Contributions for continuing coverage will not exceed the contributions assessed for each Plan Participant by class of coverage under the Benefit Plan.
2. The Plan Administrator will be responsible for notifying the Spouse of the right to continue and for billing and collection of contributions. However, if the Claims Administrator has been furnished with the home address of the surviving Spouse at the time of death and have been notified by the Group in an acceptable manner of the death of the Plan Participant, the Claims Administrator will notify the surviving Spouse of the right to continue. The Group will remain responsible for billing and collection of contributions.
3. Coverage continues, as long as contributions are paid timely, until the earliest of:
- a. the date contributions are due and not paid on a timely basis;
 - b. the date the surviving Spouse or a Dependent becomes eligible for Medicare;
 - c. the date the surviving Spouse or a Dependent becomes eligible to participate in another group health plan;
 - d. the date the surviving Spouse remarries or dies;
 - e. the date this Group Benefit Plan ends; or
 - f. the date a Dependent is no longer eligible.

B. 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. See 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 Plan Participant, the Plan Participant's Spouse and the Plan Participant'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 Plan Participants 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 Amount, and Out-of-Pocket Amount 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:

1. termination of employment of a covered Employee for reasons other than gross misconduct;
2. loss of eligibility by a covered Employee due to a reduction in the number of work hours of the Employee;
3. death of a covered Plan Participant;
4. divorce or legal separation between a covered Plan Participant and their Spouse;
5. the covered Plan Participant becomes entitled to Medicare benefits resulting in the loss of coverage for Dependents;
6. a Dependent child ceases to be an Eligible Dependent under the terms of this Benefit Plan; or
7. 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 sixty (60) days of the event:

1. divorce or legal separation,
2. becoming entitled to Medicare, or
3. 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:

1. begins no later than the date on which a Plan Participant otherwise would lose coverage under the Group health plan (the coverage end date); and
2. ends sixty (60) days after the coverage end date or sixty (60) days after the Plan Participant 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 Plan Participant 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. The Plan Participant 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:

1. 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
2. thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or

3. the date the Employer ceases to maintain any Group health plan for its Employees; or
4. the date coverage ceases because of nonpayment of required premiums when due; or
5. 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
6. 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 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:

1. the Employee or former Employee dies;
2. the Employee or former Employee becomes entitled to Medicare (under Part A, Part B, or both);
3. the Employee or former Employee and Dependent Spouse divorce;
4. 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 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 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 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.

C. 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 twenty-four (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 Benefit Plan immediately before 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 they are 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 contributions. If the leave of absence lasts thirty (30) days or less, the Employee may be required to pay the required contribution for coverage. However, if the military leave of absence lasts more than thirty (30) days, the Employee may be required to pay up to one hundred two percent (102%) of the contribution under the Benefit 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 contributions 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 Blue Cross and Blue Shield of Louisiana. In all cases, the Employer should be consulted on how this provision applies to their Employer Group sponsored plan.

Contact your Employer to ask for more details on how USERRA and other continuation coverage rights apply.

ARTICLE XIX. COORDINATION OF BENEFITS

A. Applicability

This section applies when a Plan Participant 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 Plan Participant. 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 Plan Participant 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 Plan Participant 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:
 - (a) 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.
 - (b) 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.lidi.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 AND PLAN PARTICIPANTS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP AND ALL PLAN PARTICIPANTS. THE GROUP IS THE PLAN SPONSOR FOR THIS PLAN.

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

A. This Benefit Plan

1. 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 Claims Administrator liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Group will be the administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those specifically undertaken by the Claims Administrator 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 Plan Participant for illness or bodily injury otherwise covered under this Benefit Plan when the illness or bodily injury arises out of 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 Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group's failure to do so.
3. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.
4. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.
5. The Plan Administrator shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.
6. The Claims Administrator 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 Claims Administrator under this Benefit Plan may be performed by the Claims Administrator or any of its subsidiaries, affiliates, subcontractors, or designees.

B. Section 1557 Grievance Procedure

Blue Cross and Blue Shield of Louisiana does not discriminate on the basis of race, color, national origin, sex, age or disability. Blue Cross and Blue Shield of Louisiana 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 Blue Cross and Blue Shield of Louisiana 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 Blue Cross and Blue Shield of Louisiana to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

1. Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date You become aware of the alleged discriminatory action.
2. 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.
3. 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 Blue Cross and Blue Shield of Louisiana 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.
4. The Section 1557 Coordinator will issue a written decision on the grievance no later than thirty (30) days after it is received.
5. You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within fifteen (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 thirty (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
1-877-696-6775

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within one hundred eighty (180) days of the date of the alleged discrimination.

Blue Cross and Blue Shield of Louisiana 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. Amending and Terminating the Benefit Plan

The Employer intends to maintain this Benefit Plan indefinitely; however, it reserves its right, at any time, to amend, suspend or terminate the Benefit Plan in whole or in part. This includes amending the Benefits under the Plan or the trust agreement, if any.

D. Identification Cards and Benefit Plans

The Claims Administrator will prepare an ID card for each Plan Participant. The Claims Administrator will issue a Benefit Plan to the Group and print a sufficient number of copies of the Benefit Plan for the Group's Plan Participants. At the direction of the Group, the Claims Administrator will either deliver all materials to the Group for the Group's distribution to the Plan Participants, or deliver the Plan Participant materials directly to each Plan Participant. The Plan Participant's copy of the Benefit Plan shall serve as the certificate of coverage. Unless otherwise agreed between the Group and the Claims Administrator, the Group has the sole responsibility for distributing all such documents to Plan Participants.

E. Benefits to Which Plan Participants are Entitled

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Benefit Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.
2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.
3. Continuity of healthcare services.
 - a. Upon the termination of a contractual agreement with a Provider, notification of the removal of the Provider from the Preferred Care PPO Provider Network will be given by the Claims Administrator to any Plan Participant who has begun a course of treatment by the Provider.
 - b. A Plan Participant 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 ninety (90) days after the Claims Administrator notifies the Plan Participant that the Provider has left the Preferred Care PPO 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 Plan Participant voluntarily chooses to change Providers.
 - (4) The Plan Participant moves outside of the geographic service area of the Provider or the Preferred Care PPO Provider Network.
 - (5) The Plan Participant's condition does not meet the requirements to be deemed a Serious and Complex Condition.

F. Termination of a Plan Participant's Coverage

1. The Claims Administrator may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of this 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 or covered Plan Participant or Dependent, shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective Date of coverage or terminated within three (3) years of the Effective Date, for fraud or intentional misrepresentation of material fact. The Claims Administrator will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If the Plan Participant enrolls someone that is 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, coverage terminates as provided below:
 - a. The Plan Participant's coverage and that of all the Dependents automatically, and without notice, terminates on the date of termination.
 - b. The coverage of the Plan Participant's Spouse will terminate automatically, and without notice, on the date of a final decree of divorce or other legal termination of marriage.
 - c. The coverage of a Dependent will terminate automatically, and without notice, on the date the Dependent ceases to be an eligible Dependent.
 - d. Upon the death of a Plan Participant, the coverage of all surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if contributions have been paid through that period. However, a surviving Spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.
3. In the event the Group cancels this Benefit Plan, such cancellation or termination alone will operate to end all rights to Benefits under this Benefit Plan as of the Effective Date of such cancellation or termination. The Group shall have the obligation to notify its Plan Participants and beneficiaries of such cancellation or termination. The Claims Administrator has no such obligation of notification at the Plan Participant level.
4. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Plan Participant for Covered Services rendered after the date of cancellation or termination of coverage.

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

G. Filing of Claims

1. The Plan Participant 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 Plan Participants that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Plan Participant. However, if the Plan Participant must file a Claim to access the Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim form.

Plan Participants 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 the Claims Administrator, may require the signature of the dispensing pharmacist. The Claim form should then be sent to the Pharmacy Benefit Manager, whose telephone number is found on the ID card.

H. 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. If any provision of this Benefit Plan conflicts with any law of the State of Louisiana or the United States of America, the provision is automatically amended to meet the minimum requirements of the statute or regulation. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

I. 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.

J. Release of Information

The Claims Administrator may request that the Plan Participant or the Provider furnish certain information relating to the Plan Participant's Claim for Benefits. The Claims Administrator will hold such information, records, or copies of records as confidential except where in the Claims Administrator's discretion the same should be disclosed.

K. Assignment

1. A Plan Participant's rights and Benefits payable under this Benefit Plan are personal to the Plan Participant and may not be assigned in whole or in part by the Plan Participant. The Claims Administrator will recognize assignments of Benefits to Hospitals if both this Benefit Plan and the Provider are subject to La. R.S. 40:2010. If both this Benefit Plan and the Provider are not subject to La. R.S. 40:2010, the Claims Administrator will not recognize assignments or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the Plan or the Claims Administrator liable to any third-party to whom a Plan Participant may be liable for the cost of medical care, treatment, or services.
2. The Claims Administrator reserves the right to pay PPO Providers and Hospitals, and Providers and Hospitals in the Claims Administrator's Participating Provider Network directly instead of paying the Plan Participant.

L. Plan Participant and Provider Relationship

1. The choice of a Provider is solely the Plan Participant's.
2. The Claims Administrator and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. The Claims Administrator does not render Covered Services, but only makes payments on behalf of the Plan for Covered Services that the Plan Participant receives. Neither the Plan nor the Claims Administrator will be held liable for any act or omission of any Provider, or for any Claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any Provider or in any Provider's facilities. The Plan and the Claims Administrator have no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.
3. The use or non-use of an adjective such as Preferred Network, Participating, and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

M. 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 elect 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 who 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 Claims Administrator's Allowable Charge. When an Allied Provider or Physician is not required by Medicare to accept the Medicare approved amount as payment in full, the Claims Administrator will base Benefits on the lesser of the Medicare approved amount plus Medicare's limiting charge, if applicable, or the Claims Administrator's Allowable Charge.

N. Notice

Any notice required under this Benefit Plan must be in writing. Any notice required to be given to a Plan Participant will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Plan Participant at the address the same appears on the Claims Administrator's records. Any notice that a Plan Participant must give the Group at the address as the same appears in this Benefit Plan. The Group, the Claims Administrator, or a Plan Participant may, by written notice, indicate a new address for giving notice.

O. 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 Plan Participant 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 Benefits are initially extended by the Plan and a compensation carrier, employer, governmental agency or program, insurer, or any other entity makes any type of settlement with the Plan Participant, with any person entitled to receive settlement when the Plan Participant dies, or if the Plan Participant's injury or illness is found to be compensable under federal or state workers' compensation laws or programs, the Group or the Plan Participant must reimburse the Plan for Benefits extended or direct the compensation carrier, employer, governmental agency, or program, insurer, or any other entity to make such reimbursement. The Plan will be entitled to such reimbursement even if the settlement does not mention or excludes payment for healthcare expenses.

P. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Group will be subrogated and will succeed to the Plan Participant's right for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier even where such carrier provides benefits directly to a Plan Participant who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights
2. The Plan Participant will reimburse the Group all amounts recovered by suit, settlement, or otherwise from any third-party or the Plan Participant's insurer to the extent of the Benefits provided or paid under this Benefit Plan. The Group's right to reimbursement comes first even if the Plan Participant is not paid for all of the Plan Participant's Claim for damages against the other person or organization or even if the payment the Plan Participant receives is for, or is described as for, the Plan Participant's damages other than healthcare expenses, or if the Plan Participant recovering the money is a minor. All costs that the Plan Participant incurs (including attorney fees) in exercising any right of recovery will be the Plan Participant's responsibility. Amounts that the Benefit Plan paid for which a third-party or insurer is responsible will not be reduced by the amount of the Plan Participant's costs. The Plan Participant shall hold in trust for the account of the Group all amounts recovered, up to the total amount of Benefits paid. The Group appoints the Plan Participant as its representative for such limited purpose only.
3. The Plan Participant will take such action, furnish such information and assistance, and execute such papers as may be required to facilitate enforcement of the Group's rights, and will take no action prejudicing the rights and interest of the Group under this Benefit Plan. The Group and its designees have the right to obtain and review the Plan Participant's medical and billing records if the Group and its designees determine in their sole discretion, that such records would be helpful in pursuing the right of subrogation and reimbursement. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits Article of this Benefit Plan.
4. The Plan Participant must notify the Group of any Accidental Injury.

Q. Right of Recovery

Whenever any payment for Covered Services has been made by the Claims Administrator in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan or exceeds the Allowable Charge, or whenever payment has been made in error by the Claims Administrator for non-Covered Services, the Claims Administrator will have the right to recover such payment from the Plan Participant or, if applicable, the Provider. As an alternative, the Claims Administrator reserves the right to deduct from any pending Claim for payment under this Benefit Plan any amounts that the Plan Participant or Provider owes the Plan.

R. Coverage in a Department of Veterans Affairs or Military Hospital

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from the Benefit Plan to the extent the veteran would be eligible for Benefits for such care or services from the Benefit Plan if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

The United States will have the right to collect from the Benefit Plan 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 the Benefit Plan if the retiree or Dependent were to incur such cost on their own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

S. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, the Association permitting Blue Cross and Blue Shield of Louisiana to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association.

The Plan Administrator, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Plan Administrator for any of Blue Cross and Blue Shield of Louisiana's obligations created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of the claims administration agreement.

T. Out-of-Area Services

Blue Cross and Blue Shield of Louisiana has a variety of relationships with other Blue Cross 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 Blue Shield Association. Whenever the Plan Participant receives healthcare services outside the geographic area served by Blue Cross and Blue Shield of Louisiana, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When the Plan Participant receives care outside of the service area, the Plan Participant will receive care from one of two kinds of Providers: either Participating or Non-Participating. Most Participating Providers contract with the local Blue Cross or Blue Shield Licensee in that geographic area (Host Blue). Non-Participating Providers do not contract with the Host Blue. We explain below how the Claims Administrator pays both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, except for all dental care Benefits (except when paid as medical Benefits), and those Prescription Drug Benefits or vision care Benefits that may be administered by a third-party contracted by the Claims Administrator to provide the specific service or services.

1. BlueCard® Program

Under the BlueCard® Program, when the Plan Participant receives Covered Services within the geographic area that a Host Blue serves, the Claims Administrator will remain responsible for doing what it agreed to in the plan. But, the Host Blue must contract with and generally handle all interactions with its Participating Providers.

When the Plan Participant receives Covered Services outside the service area and the Claim is processed through the BlueCard® Program, the amount the Plan Participant pays for the Covered Services is calculated based on one of the following, as determined by the Claims Administrator:

- a. the billed charges for the Plan Participant's Covered Services;
- b. the negotiated price that the Host Blue makes available to the Claims Administrator; or
- c. 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 the healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for overestimation or underestimation of past pricing of Claims, as noted above. Those adjustments will not affect the price the Claims Administrator used for the Plan Participant's Claim because the Claims Administrator will not apply them after a Claim has already been paid.

2. Special Case: Value-Based Programs

a. BlueCard® Program

Under a Value-Based Program, if the Plan Participant receives Covered Services in a Host Blue's service area, the Plan Participant will not have to pay any of the Provider Incentives, risk-sharing, or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

b. Negotiated (non-BlueCard® Program) Arrangements

If the Claims Administrator has a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on the Plan Participant's behalf, the Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as for the BlueCard® Program.

3. Inter-Plan Programs: Federal and State Taxes and Surcharges or Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-insured accounts. If it applies, the Claims Administrator will include any surcharge, tax or other fee as part of the Claim charge passed on to the Plan Participant.

4. Non-Participating Providers Outside the Service Area

a. Plan Participant Liability Calculation

When the Plan Participant goes outside of the service area to Non-Participating Providers for Covered Services, the Claims Administrator will normally base the amount the Plan Participant pays on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements that state law

requires. In these situations, the Plan Participant may have to pay the difference between the amount that the Non-Participating Provider bills and how much the Claims Administrator pays for the Covered Services as stated in this paragraph. Federal or state law may govern payments for Non-Network Emergency Medical Services.

b. Exceptions

In certain situations, the Claims Administrator may use other payment methods, such as billed charges for Covered Services, the payment the Claims Administrator would make if the healthcare services had been obtained within the service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services from Non-Participating Providers. In these situations, the Plan Participant may have to pay the difference between the amount that the Non-Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as stated in the Benefit Plan.

5. Blue Cross Blue Shield Global® Core

If the Plan Participant is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (BlueCard® service area), the Plan Participant may be able to take advantage of the Blue Cross Blue Shield Global® Core for Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program in certain ways. For instance, although the Blue Cross Blue Shield Global® Core helps the Plan Participant access a network of Inpatient, Outpatient and professional Providers, Host Blue does not serve the network. When Plan Participants go to Providers outside the BlueCard® service area, the Plan Participant will typically have to pay the Providers and submit Claims.

For medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, call:

Blue Cross Blue Shield Global® Core service center
24 hours a day, 7 days a week
1-800-810-BLUE (2583)

or call collect:

1-804-673-1177

Working with a medical professional, an assistance coordinator, will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if the Plan Participant contacts the Blue Cross Blue Shield Global® Core service center for help and the Provider agrees to accept a guaranteed payment, Hospitals will not require the Plan Participant to pay for covered Inpatient services, except for the Deductible Amount and Coinsurance. The Hospital will submit Claims to the Blue Cross Blue Shield Global® Core service center. But, if the Provider does not agree to a guaranteed payment or the Plan Participant otherwise paid in full when services were received, the Plan Participant must submit a Claim to be reimbursed. The Plan Participant must contact the Claims Administrator for Authorization for non-Emergency Inpatient services, as explained in the Care Management Article and meet other requirements of this Benefit Plan for services to be provided, including, but not limited to, receiving only Medically Necessary services.

b. Outpatient Services

If the Plan Participant goes to Physicians, Urgent Care Centers and other Outpatient Providers outside the BlueCard® service area, typically the Plan Participant must pay in full at the time of service. To be reimbursed, the Plan Participant must submit a Claim.

c. Exceptions

In situations where the Blue Cross Blue Shield Global® Core service center is unable to obtain a guaranteed payment for a Global® Core claim, the Claims Administrator may use other payment methods to figure the payment the Claims Administrator will make for the healthcare services that were delivered outside the service area. Those other payment methods include, but are not limited to, billed charges for Covered Services, the payment the Claims Administrator would make if the healthcare services had been obtained within the service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services from Non-Participating Providers. In these situations, the Plan Participant needs to comply with the requirements of the Benefit Plan. The Plan Participant may have to pay the difference between the amount that the Provider bills and the payment the Claims Administrator will make for the Covered Services.

d. Submitting a Blue Cross Blue Shield Global® Core Claim

When the Plan Participant pays for Covered Services outside the BlueCard® service area, the Plan Participant must submit a Claim to be reimbursed. For institutional and professional Claims, fill out a Blue Cross Blue Shield Global® Core Claim form. Send the Claim form with the Provider's itemized bills to the Blue Cross Blue Shield Global® Core service center at the address on the form.

Make sure to follow the instructions on the form. For a copy of the form, contact the Claims Administrator or the Blue Cross Blue Shield Global® Core service center, or go to www.bcbsglobalcore.com.

For help submitting the Claim, call:

Blue Cross Blue Shield Global® Core service center

24 hours a day, 7 days a week
1-800-810-BLUE (2583)

or call collect:

1-804-673-1177

U. HIPAA Certificates of Creditable Coverage

A certificate of Creditable Coverage or similar document will be issued to an individual, if requested within twenty-four (24) months after coverage under this Benefit Plan ceases.

V. 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 Plan Participants 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, 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 Plan Participants 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 Plan Participant when they join the Benefit Plan. This disclosure must be provided to Medicare-eligible active working Plan Participants and their Dependents, Medicare-eligible COBRA Plan Participants and their Dependents, Medicare-eligible disabled Plan Participants covered under its Prescription Drug plan and any Retirees and their Dependents. The MMA imposes a late enrollment penalty on Plan Participants who do not maintain creditable coverage for a period of sixty-three (63) days or longer following their initial enrollment period for the Medicare Prescription Drug Benefit. Accordingly, this information is essential to a Plan Participant'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 provided to the Claims Administrator by the Group, the Claims Administrator shall provide, without charge, Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to Medicare-eligible Plan Participants 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 sixty (60) days from the beginning of a Plan Year (contract year, renewal year), within thirty (30) days after termination of a Prescription Drug Plan, or within thirty (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*.

W. Continued Coverage During a Leave of Absence

1. Family Medical Leave

The Family Medical Leave Act (FMLA) allows eligible Employees to take up to twelve (12) weeks of unpaid FMLA leave in a 12-month period for the following reasons:

- a. a serious health condition that makes the Employee unable to perform their job;
- b. to care for a seriously ill dependent child, spouse or parent; or
- c. for the birth, placement for adoption or foster care of a child.

A serious health condition is an illness, injury, impairment, or physical/mental condition involving either Inpatient care or continuing treatment by a healthcare Provider. Leave may be taken intermittently or on a reduced schedule only if Medically Necessary. If leave is taken on an intermittent basis, the arrangement must be agreed to in advance by the Employee and the Group. Certification of a serious health condition must be provided in writing to the Group. To be eligible for FMLA, an Employee must have completed twelve (12) months of employment and have worked at least one thousand two hundred fifty (1,250) hours during the twelve (12) month period preceding the leave requested.

The Plan will continue coverage for the Employee 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 the Pregnancy Discrimination Act, and any amendments or successor provisions, as long as eligibility criteria under the laws continue to be met. If the Employee's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, the Employee is entitled to re-enroll for coverage. If the Employee is not restored to active full-time employment by the end of the leave of absence period, the Employee will cease to be eligible and coverage for the Employee 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 the Termination of a Plan Participant's Coverage section of this Benefit Plan.

2. Other Employer-Approved Leave of Absence

When an Employee has been granted a documented, approved leave of absence by the Employer, the Plan will maintain coverage for the Employee and any covered Dependents for a period not to exceed ninety (90) days. The Employee must remain a bona fide Employee of the Group during the approved leave period.

The Employer will provide the Claims Administrator with proof of the documented leave, upon request. If the Employer terminates the Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in the Termination of a Plan Participant's Coverage section of this Benefit Plan.

X. Compliance with HIPAA Privacy Standards

Certain Employees of the Employer's workforce perform services in connection with administration of the Benefit Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards of Privacy of Individually Identifiable Health Information (45 CFR Part 164, the Privacy Standards), these Employees are permitted to have such access subject to the following:

1. General

The Plan shall not disclose Protected Health Information to any Employee of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. Protected Health Information shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

Protected Health Information disclosed to Employees of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and healthcare operations. The terms payment and healthcare operations shall have the same definitions as set out in the Privacy Standards, the term payment generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of Benefits or reimbursement for healthcare. Healthcare Operations generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of healthcare Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

3. Authorized Employees

Protected Health Information shall be disclosed on to Employees of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Benefit Plan. For purposes of this HIPAA Privacy section, Employees of the Employer's workforce shall refer to all Employees and other persons under the control of the Employers.

- a. Updates Required. The Employer shall amend the plan promptly with respect to any changes in the Employees of its workforce who are authorized to receive Protected Health Information.
- b. Use and Disclosure Restricted. An authorized Employee of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform duties with respect to the Benefit Plan.

- c. Resolution of Issues of Noncompliance. In the event that any Employee of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:
 - (1) investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;
 - (3) mitigating any harm caused by the breach, to the extent practicable; and
 - (4) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Employer

The Employer must provide certification to the Plan that it agrees to:

- a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
- b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Employer;
- d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;
- f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;
- h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- j. ensure the adequate separation between the Plan and Employee of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

Those Employees of the Employer's workforce that are designated as authorized to receive Protected Health Information from the Comprehensive Medical Benefit Plan (the Plan) in order to perform their duties with respect to the Plan can be found on the Schedule of Benefits.

Y. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the Security Standards), the Employer agrees to the following:

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. Electronic Protected Health Information shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections 3. Authorized Employees and 4. Certification of Employers described above in this section.

Z. Value-Added Services

The Claims Administrator may from time to time provide Value-Added Services to the Plan Administrator. These Value-Added Services may be provided to the Plan Administrator directly by the Claims Administrator, 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 Benefit Plan or any other policy of insurance. The Plan Administrator is never under any obligation to accept Value-Added Services, and the Claims Administrator may cease offering and paying for Value-Added Services at any time.

AA. Our Right to Offer Premium Incentives

The Claims Administrator may, at its discretion, offer rebates, refunds, reductions of premium, or other items of value, in amounts or types determined by the Claims Administrator, for business purposes and healthcare quality and improvement purposes, including but not limited to the following purposes:

1. Encouraging Plan Participants and/or policyholders to participate in quality programs;
2. Ensuring Plan Participants and/or policyholders are better able to afford benefits packages;
3. Reducing and alleviating social determinants of health;
4. Reducing transition costs for Plan Participants and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;
5. Rewarding Plan Participants and/or policyholders for choosing lower cost, quality healthcare Providers;
6. Rewarding Plan Participants and/or policyholders for selecting lower cost, quality healthcare goods and products;
7. Rewarding Plan Participants 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 Plan Participants and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

ARTICLE XXI.

COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The Claims Administrator wants to know when a Plan Participant is dissatisfied about the care or services received from the Claims Administrator or one of its Providers. Plan Participants may register a Complaint, or file a formal written Grievance about the Claims Administrator or a Provider by following the procedures outlined below.

The Plan considers a written Appeal as the Plan Participant's request to change an Adverse Benefit Determination made by the Claims Administrator. An Appeal is defined as a request from a Plan Participant or their authorized representative to change a previous decision made by the Claims Administrator about Covered Services. Examples of issues that qualify as Appeals include denied Authorizations, Claims denied based on adverse determinations of Medical Necessity, or other Adverse Benefit Determinations. Adverse Benefit Determinations include denials of and reductions in Benefit payments.

Appeal rights for Plan Participants are outlined below, after the Complaint, Grievance, and Informal Reconsideration Procedures. In addition to the Appeal rights, the Plan Participant's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of the Claims Administrator's coverage decisions when the coverage decision concerns Medical Necessity or Investigational determinations.

An Expedited Appeals process is available for situations where the time frame of the standard medical Appeal 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 the Claims Administrator's services, access, availability or attitude and those of the Claims Administrator's Network Providers. A quality of care concern addresses the appropriateness of care given to a Plan Participant.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with the Claims Administrator or with Provider services.

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

Medical Benefits: call 1-800-599-2583 or 1-225-291-5370

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with the Claims Administrator or with Provider services. If the Plan Participant does not feel their Complaint was adequately resolved or the Plan Participant 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 Plan Participant may call the Claims Administrator's customer service department.

Send written Grievances to:

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

A response will be mailed to the Plan Participant within thirty (30) business days of receipt of the Plan Participant's written Grievance.

3. Informal Reconsideration

An Informal Reconsideration is a request by telephone, made by an authorized Provider to speak to the Claims Administrator's Medical Director or a peer reviewer on the Plan Participant's behalf about a Utilization Management decision that the Claims Administrator has made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

An Informal Reconsideration is available only for initial determinations that are requested within ten (10) days of the denial or Concurrent Review determinations. The Claims Administrator will conduct an Informal Reconsideration within one (1) working day of 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.

For ERISA Plans, the Plan Participant is required to complete the mandatory first level of Appeal prior to instituting any civil action against the Group under ERISA section 502(a).

The Plan Participant should contact the Employer, Plan Administrator, Plan Sponsor, or the customer service department at 1-800-599-2583 or 1-225-291-5370 if the Plan Participant is unsure whether ERISA is applicable. The Plan Participant may also call the customer service department if they have questions or need assistance putting the Appeal in writing.

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

The Claims Administrator will determine if the Plan Participant's Appeal is an administrative Appeal or a medical Appeal. There are two (2) levels of each Appeal.

Plan Participants are encouraged to provide the Claims Administrator with all available information to help completely evaluate the Appeal such as written comments, documents, records, and other information related to the Adverse Benefit Determination. Upon request by the Plan Participant and free of charge, the Claims Administrator will provide reasonable access to and copies of all documents, records, and other information relevant to the Adverse Benefit Determination.

The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in their Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in review of an Adverse Benefit Determination. The authorized representative may be the Plan Participant's treating Provider, if the Plan Participant 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 that is determined to be experimental or Investigational.

All administrative Appeals should be submitted in writing to:

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

a. First Level Administrative Appeals

If a Plan Participant is not satisfied with the Claims Administrator's decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of the initial Adverse Benefit

Determination for first level administrative Appeals. Requests submitted to the Claims Administrator after one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. If the administrative Appeal is overturned, the Claims Administrator will reprocess the Plan Participant's Claim, if any. If the administrative Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The administrative Appeal decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request; unless it is mutually agreed that an extension of time is warranted.

b. Second Level Administrative Appeals

After review of the Claims Administrator's first level Appeal decision, if a Plan Participant is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of receipt of the first level Appeal decision. Requests submitted after sixty (60) calendar days of receipt of the first level Appeal decision will not be considered.

An 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 Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within five (5) days of the committee meeting.

2. Medical Appeals

Medical Appeals involve Adverse Benefit Determinations for Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or that is determined to be experimental or Investigational and any related prospective or retrospective review determination.

All medical Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana
Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

a. First Level Medical Appeals (Internal)

If a Plan Participant is not satisfied with the Claims Administrator's decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination for internal medical Appeals.

Requests submitted to the Claims Administrator after one hundred eighty (180) days of receipt of the 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, the Claims Administrator will reprocess the Plan Participant's Claim, if any. If the internal medical Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The internal medical Appeal decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request; unless it is mutually agreed that an extension of time is warranted.

b. Second Level Medical Appeals (External)

If the Plan Participant still disagrees with the determination of their Claim, the Plan Participant or their authorized representative must send their written request for an External Appeal, to be conducted by a non-affiliated Independent Review Organization (IRO), within four (4) months of receipt of the internal Appeal decision.

Requests submitted to the Claims Administrator after four (4) months of receipt of the internal Appeal decision will not be considered. The Plan Participant is 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.**

The Claims Administrator will provide all pertinent information necessary to conduct the external Appeal. The external review will be completed within forty-five (45) days of receipt of the external Appeal request. The IRO will notify the Plan Participant or their authorized representative and all appropriate Providers of its decision.

The IRO decision is considered final and binding.

C. Expedited Appeals

The Expedited Appeal process is available for review of an Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize the Plan Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision. An Expedited Appeal also includes requests concerning an Admission,

availability of care, continued stay, or healthcare for a Plan Participant 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 is available to, and may be initiated by the Plan Participant, the Plan Participant's authorized representative, or a Provider authorized to act on the Plan Participant'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:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

If You need help or have questions about Your Appeal rights, call the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA or 1-866-444-3272.

1. Expedited Internal Medical Appeals

In these cases, the Claims Administrator will make a decision no later than seventy-two (72) hours of receipt of an Expedited internal medical Appeal request that meets the criteria for an Expedited Appeal.

In any case where the Expedited internal medical Appeal process does not resolve a difference of opinion between the Claims Administrator and the Plan Participant or the Provider acting on behalf of the Plan Participant, 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 medical Appeal is a request for immediate review, by an Independent Review Organization. The request may be simultaneously filed with a request for an Expedited internal medical Appeal, since the IRO assigned to conduct the Expedited External medical review will determine whether the request is eligible for an external review at the time of receipt. The Claims Administrator will forward all pertinent information for Expedited External medical Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

D. No Surprises Act (NSA) Internal Appeals and External Appeals

The NSA added certain Plan Participant rights and protections that may result in a Plan Participant being eligible for internal Appeals and External Appeals. If a Plan Participant is dissatisfied about decisions the Claims Administrator makes regarding the Plan Participant's rights and protections added by the NSA, the Plan Participant may file an Appeal. Examples of the NSA Plan Participant rights and protections include the following:

1. Plan Participant cost sharing and surprise billing protections for Emergency Medical Services;
2. Plan Participant cost sharing and surprise billing protections related to care provided by Non-Network Providers at Network facilities;
3. Whether Plan Participants are in a condition to receive notice and provide Informed Consent to waive the NSA protections; and
4. Whether a Claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to Plan Participant cost sharing and surprise billing.

The Plan Participant is encouraged to, and should, provide the Claims Administrator with all available information to help completely evaluate the NSA Appeal such as written comments, documents, records, and other information.

The Claims Administrator will provide the Plan Participant, 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 Plan Participant has the right to appoint an authorized representative for NSA Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in an internal Appeal or External Appeal. The authorized representative may be the Plan Participant's treating Provider if the Plan Participant appoints the Provider in writing.

1. NSA Internal Appeals

If a Plan Participant believes that the Claims Administrator has not complied with the surprise billing and cost sharing protections 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 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:

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

If a Plan Participant has questions or needs assistance, the Plan Participant may call the Claims Administrator's customer service department at the number on the ID card.

The Claims Administrator will investigate the Plan Participant's concerns. If the NSA internal Appeal is overturned, the Claims Administrator will reprocess the Plan Participant's Claim, if applicable. If the NSA internal Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the NSA External Appeal process.

The NSA internal Appeal decision will be mailed to the Plan Participant, the Plan Participant's authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) days of receipt of the Plan Participant's request, unless it is mutually agreed that an extension of time is warranted.

2. NSA External Appeals

If a Plan Participant 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 the Claims Administrator 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:

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

If the Plan Participant has questions or needs assistance, the Plan Participant may call the Claims Administrator's customer service department at the number on the ID card.

A Plan Participant must exhaust all NSA internal Appeal opportunities prior to requesting an NSA External Appeal conducted by an IRO.

The Claims Administrator 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 receipt of the request for an NSA External Appeal. The IRO will notify the Plan Participant, the Plan Participant's authorized representative, or a Provider authorized to act on the Plan Participant's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Plan Participant and the Claims Administrator for purposes of determining coverage under this Benefit Plan. This NSA External Appeal process shall constitute the Plan Participant's sole recourse in disputes concerning whether the Claims Administrator 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 Plan Participant may contact 1-800-985-3059 or visit www.cms.gov/nosurprises for more information about Plan Participant rights under the NSA.

ARTICLE XXII. ERISA RIGHTS

To the extent this is an ERISA plan, the Plan Participant 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 and beneficiaries shall be entitled to:

A. Receive Information about the Plan and Benefits

1. A Plan Participant 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 health benefit 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 Plan Participant may obtain copies of documents governing the operation of the Plan, including health benefit contracts and collective bargaining agreements, and a copy 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 Plan Participant may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

An Employee may continue healthcare coverage for the Employee or the Dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. The Employee or the Dependents may, however, have to pay for such coverage. A Plan Participant may also review this document and the Summary Plan Description governing the Plan on the rules pertaining to the participant's COBRA continuation of coverage rights.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, 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 Plan Participant and other beneficiaries. No one, including the Employer, union or any other person, may fire the Plan Participant or otherwise discriminate against the Plan Participant or beneficiaries in any way to prevent them from obtaining a Plan Benefit or exercising their rights under ERISA.

The Plan Administrator will not discriminate on the basis of race, color, religion, national origin, disability, sex, gender identity, sexual orientation, age, protected veteran or disabled status or genetic information; and shall not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.

D. Enforce Plan Participant's Rights

1. If a Plan Participant's Claim for a Plan Benefit is denied or ignored, in whole or in part, the Plan Participant 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 Plan Participant can take to enforce the above rights. A Plan Participant must exhaust all claims and appeal procedures available before filing any suit. For instance, if the Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Plan Participant may file suit in Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Plan Participant up to one hundred ten (\$110.00) dollars a day until the Plan Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a Claim for Benefits, which is denied or ignored, in whole or in part, the Plan Participant may file suit in a state or Federal Court. In addition, if the Plan Participant 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 Plan Participant may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Plan Participant is discriminated against for asserting rights, the Plan Participant may seek assistance from the United States Department of Labor, or file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order the Plan Participant to pay these costs and fees, for example, if the court determines that the claim is frivolous.

E. Assistance with Plan Participant Questions

If a Plan Participant has any questions about the Plan, contact the Plan Administrator. If a Plan Participant has any questions about this statement or about rights under ERISA, or needs assistance in obtaining documents from the Plan Administrator, the Plan Participant 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 Plan Participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XXIII. OBTAINING CARE WHILE TRAVELING

The ID card offers convenient access to PPO healthcare outside of Louisiana. If the Plan Participant is traveling or residing outside of Louisiana and needs medical attention, please follow these steps:

1. In an Emergency, go directly to the nearest Hospital.
2. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest PPO doctors and Hospitals.
3. Use a designated PPO Provider to receive the highest level of Benefits.
4. Present the ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.
5. The Plan Participant must obtain any required Authorizations from Blue Cross and Blue Shield of Louisiana.

ARTICLE XXIV. MAKING PLAN CHANGES AND FILING CLAIMS

Blue Cross and Blue Shield of Louisiana is continuing to update its online access for Plan Participants. Plan Participants may now be able to perform many of the functions described below, without contacting the Claims Administrator's customer service department. Plan Participants are invited to log on to www.bcbsla.com for access to these services.

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of the Claims Administrator's local service offices*, or from the home office of Blue Cross and Blue Shield of Louisiana.

If the Plan Participant needs to submit documentation to the Claims Administrator, the Plan Participant may forward it to Blue Cross and Blue Shield of Louisiana at P.O. Box 98029, Baton Rouge, LA 70898-9029, or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Plan Participant has any questions about any of the information in this section, the Plan Participant may speak to the Employer or call the Claims Administrator's customer service department at the telephone number shown on the ID card.

A. Adding or Changing the Plan Participant's Family Members on the Benefit Plan

The Schedule of Eligibility Article lets the Plan Participant know when it is necessary to enroll additional family members for Dependent coverage under the Benefit Plan. Please read the Schedule of Eligibility Article and this section as they contain important information for the Plan Participant.

The Group may require the Employee to use the Employee Enrollment / Change Form to enroll family members not listed on the Employee's original enrollment form. If the Plan Participant does not complete and return a required Employee Enrollment / Change Form to the Plan Administrator so the Claims Administrator receives it within the timeframes set out in the Schedule of Eligibility Article, it is possible that the Employee's health Benefits coverage will not be expanded to include the additional family members. Completing and returning an Employee Enrollment / Change Form is especially important when the Employee's first Dependent becomes eligible for coverage or when the Employee no longer has any eligible Dependents.

The Employee may also be asked to complete the health questions for these family members. The Schedule of Eligibility Article explains when coverage becomes effective for new family members. Generally, an Employee Enrollment / Change Form is used to add newborn children, newborn adopted children, a Spouse, or other Dependents not listed on the Employee's original application for coverage. The Plan Administrator should receive the Employee's completed form within thirty (30) days of the child's birth or placement, or the Employee's marriage.

B. How to File Claims for Benefits

Blue Cross and Blue Shield of Louisiana and most Providers have entered into agreements that eliminate the need for a Plan Participant to personally file a Claim for Benefits. Preferred Providers or Participating Providers will file Claims for Plan Participants either by mail or electronically. In certain situations, the Provider may request the Plan Participant to file the Claim. If the Plan Participant's Provider does request the Plan Participant to file directly with the Claims Administrator, the following information will help the Plan Participant in correctly completing the Claim form.

The ID card shows the way the name of the Plan Participant appears on the Claims Administrator's records. If the Plan Participant has Dependent coverage, the name(s) are recorded as shown in the enrollment information the Plan received. The ID card also lists the Plan Participant's contract number (ID #). This number is the identification to the Plan Participant's membership records and should be provided each time a Claim is filed.

To assist in promptly handling of the Plan Participant's Claims, please be sure that:

1. an appropriate Claim form is used
2. the contract number (ID #) shown on the form is identical to the number on the ID card
3. the patient's date of birth is listed
4. the patient's relationship to the Plan Participant is correctly stated
5. all charges are itemized, whether on the Claim form or on the attached statement

6. the date of service (date of Admission to a Hospital or other Provider) or date of treatment is correct
7. 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)
8. the Claim form is completed and signed by the Plan Participant and the Provider

IMPORTANT NOTE: Be sure to check all Claims for accuracy. The contract number (ID #) must be correct. It is important that the Plan Participant keep a copy of all bills and Claims submitted.

C. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

When a Plan Participant or an enrolled family member is being admitted to a Preferred or Participating Provider, the Plan Participant should show the ID card to the admitting clerk. The Provider will file the Claim with the Claims Administrator. Benefit payments will go directly to the Preferred or Participating Provider. The Provider will then bill the Plan Participant directly for any remaining balance. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

2. Outpatient Department Claims

The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility. However, in some instances involving Emergencies or Outpatient treatment, the Provider may ask for payment directly from the Plan Participant. If this occurs, the Plan Participant should obtain an itemized copy of the bill, be sure the Claim form correctly notes the contract number (ID #), the patient's date of birth, as well as the patient's relationship to the Plan Participant. The Provider must mark the statement or Claim form PAID. This statement should then be sent to the Claims Administrator.

3. Emergency Room Claims

When a Plan Participant has Emergency room services performed by a Network or Non-Network Provider, the Plan Participant should show the ID card to the admitting clerk. The Provider will file the Claim with the Claims Administrator. Benefit payment will be sent directly to the Provider. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

4. Prescription Drug Claims

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

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

5. Nursing Services Claims

A receipt must be obtained for nursing services from each nurse indicating the name of the patient and the number of days covered by each receipt. Each receipt must also be signed by the nurse with the initials RN or LPN and registry number. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary must be filed with the receipts for nursing services.

6. Durable Medical Equipment (DME) Claims

Charges for rental or purchase of wheelchairs, braces, crutches, etc. must be on the bill of the supplying firm, giving a description of the item rented or purchased, the date, the charge, and the patient's name. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary may also need to be filed with these bills.

7. Mental Health and/or Substance Use Disorder Claims

For help with filing a Claim for the treatment of Mental Health and/or substance use disorders, the Plan Participant should refer to the ID card or call the Claims Administrator's customer service department.

8. Other Medical Claims

When the Plan Participant receives other medical services (clinics, Provider offices, etc.), the Plan Participant should ask if the Provider is a Preferred Provider or Participating Provider. If yes, this Provider will file the Plan Participant's Claim with the Claims Administrator. In some situations, Providers may request payment and ask the Plan Participant to file. If this occurs, the Plan Participant must be sure the Claim form is complete before forwarding to the Claims Administrator. If the Plan Participant is filing the Claim, the Claim must contain the itemized charges for each procedure or service.

NOTE: Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills. Itemized bills submitted with Claim forms must include the following:

- a. full name of patient
- b. date(s) of service
- c. description of and procedure code for service
- d. diagnosis code
- e. charge for service
- f. name and address of Provider of service

D. Claims Questions

Plan Participants can view information about the processing or payment of a Claim at www.bcbsla.com.

Plan Participants can also write the Claims Administrator at the below address or call the Claims Administrator's customer service department at the telephone number shown on the ID card or visit any of the local service offices*. If the Plan Participant calls for information about a Claim, the Claims Administrator can help the Plan Participant better if they have the information at hand, particularly the contract number, patient's name and date of service.

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

Remember, the Plan Participant 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.

*Local service offices are located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

ARTICLE XXV.

RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator

This Comprehensive Medical Benefit Plan is the Benefit Plan of the Plan Administrator, also called the Plan Sponsor. To the extent this is an ERISA plan, it is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by the Employer to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Employer shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Benefit Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Benefit Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any Claim for Benefits under this Benefit Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section.

Service of legal process may be made upon the Plan Administrator.

B. Duties of the Plan Administrator

1. to administer the Plan in accordance with its terms;
2. to interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
3. to decide disputes that may arise relative to a Plan Participant's rights;
4. to prescribe procedures for filing a Claim for Benefits and to review Claim denials;
5. to keep and maintain the Plan documents and all other records pertaining to the Plan;
6. to appoint a Claims Administrator to pay Claims;
7. to perform all necessary reporting as required by ERISA;
8. to establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609; and
9. to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

C. Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

D. Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

1. Fiduciary Duties

A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to Plan Participants and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- a. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- b. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- c. in accordance with the Plan documents to the extent they agree with ERISA.

2. The Named Fiduciary

A named fiduciary is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- a. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- b. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

3. The Claims Administrator is not a Fiduciary

A Claims Administrator is NOT a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

ARTICLE XXVI. GENERAL PLAN INFORMATION

Information about the Plan, Plan Administrator, Funding, and Agent for Service of Legal Process, etc. can be found on the Schedule of Benefits, which is incorporated by reference into this Comprehensive Medical Benefits Plan, as if physically attached hereto and made a part hereof.

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。听障客户请拨打 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).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານພຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫຼຸບໍ່ດີ, 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 بگیرید.

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)

