NGF GROUP

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SMALL BUSINESS
GROUP POINT OF SERVICE BENEFIT PLAN

HMO Louisiana

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HMO Louisiana

Thank you for choosing us!

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

My best to you,

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

Louisiana HMO Louisiana

WOMEN'S HEALTH AND CANCER RIGHTS ACT
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 benefits in connection with a mastectomy resulting from breast cancer and elects breast reconstruction, coverage will be provided for:

- all stages of reconstruction of the breast on which the 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 deductibles, coinsurance, and copayments (if any) applicable to other medical and surgical benefits provided under this plan. Information on the plan's specific deductible, coinsurance, or copayment amounts is found in the Schedule of Benefits document that is issued with your health benefit booklet.

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 your ID card.

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SMALL BUSINESS
HMO LOUISIANA, INC.
POINT OF SERVICE GROUP BENEFIT PLAN

NOTICES

HEALTHCARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTHCARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN'S NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT **WWW.BCBSLA.COM** OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON THE BACK OF YOUR IDENTIFICATION (ID) CARD.

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

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

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

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

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

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

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

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

SMALL BUSINESS
HMO LOUISIANA, INC.
POINT OF SERVICE BENEFIT PLAN
PRESCRIPTION DRUG FORMULARY NOTICES

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

This Benefit Plan covers Prescription Drugs and uses a closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Benefit Plan. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost 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 their ID card to ask whether a specific drug is included in their formulary. If a Prescription Drug is on the Plan Participant's Prescription Drug Formulary, this does not guarantee that his physician or other authorized prescriber will prescribe the drug for a particular medical condition or Mental Illness.

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 formulary, also called non-formulary drugs, are not covered.

For Prescription Drugs that are not included in the Claims Administrator's Closed 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 Participants will receive coverage for the drug that is not on the Prescription Drug Formulary. If the drug review request is not approved, Plan Participants 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 their formulary. The Plan Participant's physician or other authorized prescriber 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.

HMO LOUISIANA, INC.
POINT OF SERVICE GROUP BENEFIT PLAN

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

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

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 Plan describes Your Benefits, as well as Your rights and responsibilities under the Plan. You are encouraged to read this Benefit Plan carefully.

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

Except for necessary technical terms, common words are used to describe the Benefits provided under this Benefit Plan. "We," "Us" and "Our" means HMO Louisiana, INC. "You," "Your", and "Yourself" means the Plan Participant. 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.

A. Facts About This HMO Point of Service Benefit Plan

This is a Point of Service Benefit Plan. You have an extensive network of Providers available to You – the HMOLA Network. You can get care from Providers in Your Network, or from Providers who are not in Your network, but the Benefits will be paid at a lower level of Deductible and Coinsurance.

If You go to Providers in Your Network, You will pay the least for care and get the most value from this Benefit Plan You choose which Providers will give You care. This choice will determine the amount We pay and the amount You will pay for Covered Services.

If a Copayment is shown on the Schedule of Benefits, You must pay the Copayment amount to the Network Provider each time You receive the Covered Services listed. Most Benefits are subject to Your payment of a Deductible. After payment of Deductibles, Benefits are subject to 2 Coinsurance levels (for example, 80/20, 60/40). Your choice of a Provider determines what Coinsurance level applies to the service provided. We will pay the highest Coinsurance level for Medically Necessary services when You go to a Provider in the HMOLA Network. We will pay the lower Coinsurance level when You receive Medically Necessary services from a Provider who is not in the HMOLA Network. Deductible Amounts and Coinsurance percentages are stated on the Schedule of Benefits.

B. Claims Administrator's HMOLA Provider Network

The HMOLA Network consists of a select group of Physicians, Hospitals and other Allied Providers that have contracted with the Claims Administrator to participate as HMO Louisiana, Inc.'s Network Providers and render Covered Services to the Plan Participants. We refer to these Providers as "HMOLA Providers" "Network Providers" or "In-Network Providers". Oral Surgery Benefits are also available when rendered by Providers in the United Concordia Dental Network (Advantage Plus) or in Blue Cross and Blue Shield of Louisiana's dental network.

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

To obtain the highest level of Benefits available, the Plan Participant should always verify that a Provider is a current HMOLA Network Provider. Plan Participants may review a current paper Provider directory, check on-line at **www.bcbsla.com**, or contact the Claims Administrator's customer service department at the number listed on their ID card. Our Network may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas.

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

Additionally, Providers in Your network may be contracted to perform certain Covered Services but may not be contracted in Your network to perform other Covered Services. When a Network Provider performs services that the Network Provider is not contracted with the Claims Administrator to perform (such as certain High-Tech Imagining services or radiology procedures), Claims for those services will be adjudicated at the Non-Network Benefit level. The Plan Participant should make sure to check his Provider directory to verify that the services are In-Network when performed by the Provider or at the Provider's location.

C. Receiving Care Outside the HMOLA Network

The Plan pays a lower level of Benefits when a Plan Participant uses a Provider outside the HMOLA Network. Benefits may be based on a lower Allowable Charge, and/or a penalty may apply. The Plan Participant will usually pay Deductible and Coinsurance instead of a Copayment. Receiving care from a Non-Network Provider will result in higher Out-of-Pocket costs to the Plan Participant. Because Non-Network Providers are able to balance bill Plan Participants up to their full billed charge, Out-of-Pocket costs could be significant. The amount the Plan Participant is required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum.

It is recommended that the Plan Participant ask the Non-Network Physician or healthcare professional about their billed charges before You receive care

D. Selecting a Primary Care Physician (PC) for Plans with an Office Visit Copayment

When You enroll with HMOLA, INC. it is a requirement of this plan for you to choose a Primary Care Physician (PCP). PCPs are family practitioners, general practitioners, internists, geriatricians, pediatricians, or obstetricians/gynecologist (OB/GYN). Each member of the family may use a different PCP. PCPs may coordinate healthcare needs from Consultation to hospitalization, direct a Member to an appropriate Provider when necessary, and help assist in obtaining any required Authorizations.

A PCP serves as Your total care coordinator for non-emergent care. PCPs, when unavailable to you, will have arrangements in place to provide their patients with information on how to get care after regular office hours. In rare cases, if You have not selected a PCP and we cannot verify Your choice, a PCP may be assigned. You may select a different PCP by contacting Our Customer Service Department.

E. Using a Primary Care Physician (PCP)

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

Members pay the lowest Physician Copayment when obtaining care from a PCP. PCPs are family practitioners, general practitioners, internists, geriatricians, pediatricians, nurse practitioners, and physician assistants. Each member of the family may use a different PCP. PCPs will coordinate

health care needs from consultation to hospitalization, will direct a Member to an appropriate Provider when necessary, and will assist in obtaining any required Authorizations.

The Physician Office Copayment may be reduced or waived when services are rendered by a Provider participating in the Quality Blue Primary Care Program (QBPC). QBPC Providers include family practitioners, general practitioners, internists, geriatrician and nurse practitioners.

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

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

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

In the United States:

Emergencies: Plan Participants receive Network Benefits when covered Emergency Medical Services are provided in the Emergency Department of a Hospital.

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

Outside the United States:

Emergencies: Plan Participants receive Network Benefits when covered Emergency Medical Services are provided in the Emergency Department of a Hospital.

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

How to Get Care Outside the Service Area:

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

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

3. Use a BlueCard® Nationwide or a Blue Cross Blue Shield Global® Core Provider.

4. Present a Member ID card to the doctor or Hospital, who will verify coverage and file Claims for the Member.

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

G. 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.

See the Care Management Article of this Benefit Plan for additional information regarding Authorization requirements.

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

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

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

H. How the Plan Determines What is Paid for Covered Services

1. When a Plan Participant Uses Network Providers

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

2. When a Plan Participant Uses Participating Providers

   Participating Providers have not signed contracts with HMO Louisiana, Inc., but have signed contracts with Our parent company, Blue Cross and Blue Shield of Louisiana, or other Blue Cross and Blue Shield plans to participate in their Provider networks. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services. We use this amount to determine what to pay for the Plan Participant's Covered Services when the Plan Participant uses a Participating Provider. A Plan Participant receiving Covered Services from a Participating Provider will receive a lower level of benefit than when using a Network Provider, but the Plan Participant will not have to pay the difference between the

Allowable Charge and the Provider's billed charge. The Plan Participant will pay the amounts shown in the "Non-network" column on their Schedule of Benefits for these services.

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

3. When a Plan Participant Uses Non-Participating Providers

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

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

b. An amount We establish as the Allowable Charge; or

c. The Provider's billed charge. The Plan Participate will receive a lower level of Benefit because You did not go to a Network Provider.

The Plan Participant may pay significant costs when he uses a Non-Participating Provider. This is because the amount that some Providers charge for a Covered Service may be higher than the established Allowable Charge. Also, HMOLA Network and Participating Providers waive the difference between their actual billed charge and their Allowable Charge, while Non-Participating Providers will not.

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

Plan Participants usually pay significant costs when using Non-Participating Providers. This is because the amounts that Providers charge for Covered Services are usually higher than the fees that are accepted by HMOLA and Participating Providers. In addition, HMOLA 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 will pay the amounts shown in the "Non-Network" column on their Schedule of Benefits, and the Provider may balance bill the Plan Participant for all amounts not paid by HMO Louisiana, Inc.

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

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

EXAMPLE: A Plan Participant has this Point of Service plan with a $150 Hospital Copayment. The Non-Network Benefits are 60/40 Coinsurance with a Deductible. Assume the Plan Participant goes to the Hospital, has previously met his Deductible, and has obtained the necessary Authorization prior to receiving a non-emergency service. The Provider's billed charge for the Covered Services is $12,000. The Claims Administrator negotiated an Allowable Charge of $2,500 with its HMOLA Network

Providers to render this service. The Allowable Charge of Participating Providers is $3,000 to render this service. There is no negotiated rate with the Non-Participating Hospital.

The Plan Participant receives Covered Services from:	HMOLA Network Provider Hospital	Participating Provider Hospital	Non-Participating Provider Hospital
Provider's Bill: Allowable Charge:	$12,000 $2,500	$12,000 $3,000	$12,000 $2,500
The Plan pays:	$2,350 $2,500 Allowable Charge - $150 Copayment = $2,350	$1,800 $3,000 Allowable Charge x 60% Coinsurance = $1,800	$1,500 $2,500 Allowable Charge x 60% Coinsurance - $1,500
Plan Participant pays:	$150 Copayment 20% Coinsurance x $2500 Allowable Charge =$500	$1,200 40% Coinsurance x $3,000 Allowable Charge - $1,200	$1,000 $2,500 Allowable Charge x 40% Coinsurance = $1000
Is Plan Participant billed up to the Provider's billed charge?	NO	NO	YES - $9,500 for a total of:
Total Plan Participant pays:	$150	$1,200	$10,500

J. When a Plan Participant Purchases Covered Prescription Drugs

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

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

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

K. When a Plan Participant Receives Mental Health or 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 services for the Plan Participants. For help with these Benefits, the Plan Participant should refer to his Schedule of Benefits, his ID card, or call the Claims Administrator’s customer service department.

L. Assignment

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

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

M. Plan Participant Incentives and Value-Added Services

Sometimes the Claims Administrator offer Plan Participants coupons, discounts, and incentives to enroll in programs, such as pharmacy programs, disease management programs, and wellness programs and activities. The Claim Administrator may offer Plan Participants discounts or financial incentives to use certain Providers for selected Covered Services. The Claims Administrator 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 Plan or his 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 Claims Administrator reserve 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.

N. Health Management and Wellness Tools and Resources

The Claim Administrator offer 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 his history and habits. Exclusive discounts are also available to Members on some health services such as fitness club memberships, diet and weight control programs, vision and hearing care and more

O. Customer Service E-Mail Address

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

P. Identity Protection Services

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

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

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

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

   Group 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. In this event, Identity Protection Services will terminate at the end of the Plan year.

   Information about Identity Protection Services can be found at **www.bcbsla.com** or by calling the customer service telephone number on the back of Your identification (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, in whole or in part, based on:

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

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

C. any prospective or retrospective review determination; or

D. a Rescission of Coverage.

Allied Health Facility – An institution, other than a Hospital, licensed by the appropriate state agency where required, and/or approved by 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 Us to render Covered Services. For coverage purposes under this Benefit Plan, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, physicians assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by the Claims Administrator to render Covered Services.

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

Allowable Charge –

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

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

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

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

    3. The Provider's billed charge.

Alternative Benefits – Benefits for services not routinely covered under this Benefit Plan but which the Plan may agree to provide 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 services; (4) Organized administrative structure; and (5) Administrative, statistical and medical records.

Appeal – A written request from a Plan Participant or authorized representative to change an Adverse Benefit Determination made by the Company.

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

Authorization (Authorized) – A determination by 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. ASD includes conditions such as Autistic Disorder, Rhett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and Pervasive Development Disorder Not Otherwise Specified.

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

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

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

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

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

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

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

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

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.

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

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

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

Claim – A Claim is written or electronic proof, in a form acceptable to the Claims Administrator, of charges for Covered Services that have been incurred by a 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 – HMO Louisiana, Inc.

Complaint – An oral expression of dissatisfaction with the health plan or 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 BCBSLA, based on substantial medical literature and experience, to be a direct and consequential result of another medical condition, disease, service or treatment. Solely as an example, a pulmonary embolism after Surgery would be a Complication of the Surgery.

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

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

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

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

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

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

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 has been altered as a result of 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: personal care, homemaking, moving the patient; acting as companion or sitter; supervising medication that can usually be self-administered; treatment or services that any person may be able to perform with minimal instruction; or long-term treatment for a condition in a patient who is not expected to improve or recover. The Claims Administrator determines which services are Custodial Care.

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

Deductible Amounts

A. Individual Deductible Amount –

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

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

B. Family Deductible Amount – The dollar amount, if shown on the Schedule of Benefits, for each category of Benefits to which a deductible applies. Once a family has met its Family Deductible Amount, this Benefit Plan starts paying Benefits for all members of the family, regardless of whether each individual has met his Individual Deductible Amount.

C. Prescription Drug Deductible Amount – The dollar amount, if shown in the Schedule of Benefits, which must each Plan Participant must pay within a Benefit Period prior to paying a Prescription Drug Copayment or Coinsurance percentage. The Prescription Drug Deductible Amount does not accrue to the Individual Deductible Amount or the Family Deductible Amount.

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

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

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

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

Dependent – A person, other than the 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 recognized by the Plan as accepted medical practice, rendered because of specific symptoms, and which are directed toward detection or monitoring of a definite condition, illness or injury. A Diagnostic Service must be ordered by a Provider prior to delivery of the service.

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

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

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

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: (1) placing the health of the person, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

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

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

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

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

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. Decision to Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

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

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

B. A denial of coverage based on a determination the recommended or requested 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.

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

Full Time Equivalent (FTE) – An Employee who: (1) is employed on an average 30 or more hours per week; or (2) is working less than 30 hours per week on average, but is in the stability period defined under Internal Revenue Code §54.4980H 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 an FTE.

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 Us and not by the manufacturer or pharmacy. The Claims Administrator classifies a Prescription Drug as a Generic Drug based on a nationally recognized pricing source; therefore, all products identified as a "Generic" by the manufacturer or a pharmacy may not be classified as a Generic by the Claims Administrator.

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

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

Group – Employer or other legal entity who is the Plan Administrator and sponsor of this Plan and for whom HMO Louisiana, Inc. provides claims administration services.

Habilitative Care – Healthcare devices and services 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.

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

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 Plan.

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

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

Independent Review Organization (IRO) – An Independent Review Organization, not affiliated with the Claims Administrator, that conducts external reviews of final Adverse Benefit Determinations. The decision of the IRO is binding on both the Plan Participant and the Claims Administrator.

Infertility – The inability of a couple to conceive after one (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.

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

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

(Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge.)

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

A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the 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.

Low-Tech Imaging – Imaging services which include, but are not limited to x-rays, machine tests, diagnostic imaging and radiation therapy. If an image is defined as a High-Tech Image, then it is not a Low-Tech Image.

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

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

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

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

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

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

Network Benefits –Benefits for care received from a Network Provider.

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

Non-Network Benefits – Benefits for care received from Non-Network Providers.

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

Non-Preferred Brand/Generic Drug - Prescription Drugs that are Brand-Name Drugs or Generic Drugs that may have a therapeutic alternative called a Value Drug or a Preferred Brand Drug.

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 an impairment and/or improve functional performance. These can include the design, fabrication or application of Orthotic Devices; training in the use of orthotic and Prosthetic Devices; design, development, adaptation or training in the use of assistive devices; and the adaptation of environments to enhance functional performance.

Open Enrollment – A period of time, designated by the Group, during which an eligible Employee, retiree, elected official, officer, director and their eligible Dependents may enroll for Benefits under this Plan.

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

Out-of-Pocket Amount – The maximum amount, as shown in the Schedule of Benefits, of unreimbursable expenses, which must be paid by a Plan Participant for Covered Services in one (1) 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 26 or older, reliant on Subscriber for support, and is incapable of sustaining employment because of an intellectual or physical disability that began prior to age 26. Coverage of the Over-Age Dependent may continue after age 26 for the duration of incapacity if, prior to or within thirty-one (31) days of the Dependent Child reaching age 26, an application for continued coverage with current medical information from the Dependent Child's attending

Physician is submitted to Company. Company may require additional or periodic medical documentation regarding the Dependent Child's intellectual or physical disability as often as it deems necessary, but not more frequently than once per year after the two-year period following the child's 26th birthday. Company may terminate coverage of the Over-Age Dependent if Company determines the Dependent Child is no longer reliant on Subscriber for support or is no longer intellectually or physically disabled to the extent he is incapable of sustaining employment.

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

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

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

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

Plan – 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 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 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 Plan or the anniversary of this date and ending on the day before the next anniversary of the effective date of this Plan.

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

Preferred Brand Drug – A commonly prescribed Brand-Name Prescription Drug that has been selected based on its clinical effectiveness and safety.

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

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

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

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

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

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

Primary Care Physician (PCP) – A Physician who is a family practitioner, general practitioner, internist, geriatrician, pediatrician, or obstetrician/gynecologist (OB/GYN). When performing primary care services, a nurse practitioner and a physician assistant may be treated as a PCP.

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

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

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

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

A. HMOLA Provider – A Provider who has entered into a contract with the Claims Administrator to participate in its HMO Louisiana, Inc. Network.

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

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

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 Primary Care (QBPC) Provider – A Provider who is a family practitioner, general practitioner, internist, geriatrician, nurse practitioner or physician assistant, and who has signed an agreement to participate in the Quality Blue Program Care program.

Rehabilitative Care – Healthcare devices and services 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.

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

Rescission of Coverage - Cancellation or discontinuance of coverage that has retroactive effect. This includes a cancellation that treats a policy as void from the time of the Group's enrollment or a cancellation that voids benefits paid up to one year before the cancellation.

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

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

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

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

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

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

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

D. Utilization Review plans for all patients.

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

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Plan) within sixty (60) days of losing other certain health coverage or acquiring a new Dependent as a result of marriage, birth, adoption or placement for adoption.

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

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

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

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

C. Unique patient compliance and safety monitoring requirements.

D. Unique requirements for handling, shipping and storage.

E. Restricted access and limited distribution

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

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

Spouse – The 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 to include vaginal deliveries and caesarean sections

D. usual and related pre-operative and post-operative care; or

E. other procedures as defined and approved by the Plan.

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 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 who's Physician has advised that normal travel would be hazardous to her health.

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

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

Urgent Care – A sudden, acute and unexpected medical condition that requires timely diagnosis and treatment but does not pose an immediate threat to life or limb. Examples of Urgent Care include, but are not limited to: colds and flu, sprains, stomach aches, and nausea.

Urgent Care may be accessed from an Urgent Care Center that is in the Claims Administrator's network if a Plan Participant requires non-emergency medical care or a Plan Participant requires Urgent Care after normal business hours of a Plan Participant's Physician.

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

Utilization Management – Evaluation of necessity, appropriateness and efficiency of the use of 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. Plan Administrator is never under any obligation to accept Value-Added Services, and Claims Administrator may cease offering and paying for Value-Added Services at any time.

Value Drugs - Low-cost Generic Drugs and some low-cost Brand-Name Drugs.

Waiting Period – See Eligibility Waiting Period.

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

ARTICLE III. SCHEDULE OF ELIGIBILITY

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

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

A. Eligibility

1. Employee: To be eligible to enroll as an Employee, an individual must reside in the HMO Louisiana, Inc. Service Area and 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 this Plan's Schedule of Benefits.

    c. an elected official, officer or director who satisfies any criteria designated by the Employer, and if shown as covered in this Plan's 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 his Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Employee or his 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 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 Plan.

C. Available Classes of Coverage

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

3. Employee and Family coverage means coverage for the Employee, his 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 this Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, this Group's Benefit Plan Date will be the Effective Date of coverage.

2. If a person becomes an Eligible Person after this Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) and the enrollment form is received by the Plan 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 Plan 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 Plan within one hundred eighty (180) days of the date of birth, the Effective Date of coverage will be the date of birth.

E. Court Ordered Determination

If a court ordered determination is made to cover an eligible Dependent under an Employee's Benefit Plan, the Employee must enroll himself, if not already enrolled, and enroll the eligible Dependent by completing an enrollment form and submitting the enrollment form to the Plan 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 premium or 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 plan) are not Special Enrollees and have no special enrollment rights.

An Eligible Person who is not enrolled under this 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 Plan;

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

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

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

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

(a) the full COBRA continuation period was exhausted;

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

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

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

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

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

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

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

(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 Plan within thirty (30) days after other coverage ends (or after the Employer stops contributing toward the other non-COBRA coverage). If such enrollment is received by a HMO Louisiana, Inc. office within thirty (30) days after loss of other coverage, coverage will become effective on the date other coverage is lost. If the enrollment is not received within thirty (30) days of the loss of other coverage but is received within sixty (60) days of loss of other coverage, coverage will begin no later than the first day of the calendar month beginning after the Plan receives the request for special enrollment.

Coverage will not be available if the Plan 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 a Special Enrollment Period for an Employee or family Dependent(s) if either (1) covered under Medicaid or State Children's Health Insurance Program ("CHIP") and loses that coverage because of loss of eligibility; or (2) becomes eligible for premium assistance under the CHIP program. To qualify, the Employee must request coverage in this group health plan no later than sixty (60) days after either the date of coverage termination under Medicaid or CHIP or the date the Employee or Dependent is determined to be eligible for such premium assistance. Request for special enrollment under this section must be received by the Plan 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 Plan 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. The Employee may disenroll a child Dependent from this coverage and enroll the child in CHIP coverage effective on the first day of any month for which the child is eligible for such CHIP coverage. The Employee must promptly notify the Plan in writing of the child's disenrollment to avoid continued coverage under the Plan.

3. Special Enrollment Due to Acquiring a Dependent

   a. This 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 on 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 come on 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 he is 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) day 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 himself, his Spouse and/or the newborn/adopted child and other eligible dependent children. The enrollment must be requested by signing an enrollment form within thirty (30) days after the birth, adoption, or placement for adoption. If the enrollment form is received by the Plan within thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth, adoption, or placement for adoption. An Employee may enroll an unborn child prior to birth; however, coverage will not be effective until the date of birth. If the enrollment form is not received by the Plan 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 Plan receives the request for special enrollment. Coverage will not 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 Plan 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 himself and the new Dependents acquired because of the marriage. The enrollment must be requested by signing an enrollment form within thirty (30) days of the marriage. Coverage will become effective on the date of marriage if the enrollment form is received by a HMO Louisiana, Inc. office within thirty (30) days of the marriage. If the enrollment form is not received by Us within thirty (30) days of marriage but is received within sixty (60) days of marriage, coverage will begin no later than the first day of the calendar month beginning after the Claims Administrator receives the request for special enrollment. Coverage will not be available if the enrollment form is not signed within thirty (30) days of the marriage. Coverage will not be available if the Claims Administrator does not receive the enrollment form within sixty (60) days of marriage.

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

ARTICLE IV. BENEFITS

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

A. Benefit Categories

1. The HMO Louisiana, Inc. Point of Service Benefit Plan includes the following categories of Benefits:

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

   b. Non-Network Benefits - Benefits received from a Provider who is not contracted with HMO Louisiana, Inc. When a Plan Participant receives care from a Non-Network Provider, he will receive a lower level of Benefits on the plan.

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

2. Network Benefits

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

3. Non-Network Benefits

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

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

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

      (1) Deductible Amounts;

      (2) Coinsurance; and

      (3) Copayments that the Plan Participant pays.

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

(1) any charges in excess of the Allowable Charge;

(2) any penalties the Plan Participant or Provider must pay; and

(3) charges for non-covered services.

5. Benefits for services of a Network Provider that accrue to the Out-of-Pocket Amount for Network Providers will not accrue to the Out-of-Pocket Amount for Non-Network Providers. Benefits for services of Non-Network Providers that accrue to the Out-of-Pocket Amount for Non-Network Providers will not accrue to the Out-of-Pocket Amount for Network Providers.

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

B. Deductible Amount

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

C. Deductible Carryover

The Allowable Charges incurred for Covered Services during the months of October, November and December, which were applied toward the Benefit Period Deductible Amount, but did not satisfy the Benefit Period Deductible Amount, will be applied to the Plan Participant’s Benefit Period Deductible Amount for the next calendar year. If the Deductible Amount is met or exceeded, this Deductible carryover feature is not available. This carryover feature applies to the Benefit Period Deductible Amount only. It does not apply to Prescription Drug Deductible Amount, Family Deductible Amount or any other type of Deductible described in this Benefit Plan.

D. Copayment Services

The Plan Participant must pay a Copayment each time applicable Covered Services are rendered. The amount of the Copayment depends on the type of Network Provider rendering the service. Office visit Copayments, if applicable, will be at the Primary Care Physician or Specialist amount shown on the Schedule of Benefits.

The Physician office Copayment may be reduced or waived when services are rendered by a Provider participating in the Quality Blue Primary Care Program (QBPC).

1. Examples of Covered Services subject to Copayments:

a. Office visits and consultations;

b. Surgical procedures performed in the Physician office; and

c. Diabetes education.

2. The following services are covered at 100% of the Allowable Charge when performed by a Network Physician or other Provider who is subject to an office visit Copayment:

a. Injections, allergy serums and vials of allergy medication;

b. Allergy testing;

c. Anesthesia;

d. Chemotherapy;

e. Radiation treatment;

f. Low-Tech Imaging;

g. Lab tests;

h. Dialysis;

i. Infusion therapy; and

j. Medical and surgical supplies.

E. 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, Deductibles, Out-of-Pocket Amounts, and Benefit Period Maximums.

ARTICLE V. HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-emergency, Emergency, Pregnancy Care, Mental 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, Copayment, and any Coinsurance percentages shown in the Schedule of Benefits. The following services furnished to a Plan Participant by a Hospital are covered.

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

A. Inpatient Bed, Board and General Nursing Service

1. 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 Us.

4. In a Residential Treatment Center for Plan Participants with Mental Health or substance use disorders Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

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

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

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

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

5. medical and surgical supplies, casts, and splints;

6. Diagnostic Services rendered by a Hospital employee;

7. Physical Therapy provided by a Hospital employee; and

8. psychological testing ordered by the attending Physician and performed by a Hospital employee.

C. Emergency Room (Facility Only)

The Plan Participant must pay an Emergency Room Copayment, Deductible Amount and/or Coinsurance, if shown on the Schedule of Benefits, for each visit the Plan Participant makes to a Hospital or Allied Health Facility for Emergency Medical Services.

The Emergency Room Copayment is waived if the visit results in an Inpatient Admission Hospital Facility Service.

D. Pre-Admission Testing Benefits

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

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

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

A. Surgical Services

1. Surgery

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

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

2. Multiple 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(s)

      The secondary service(s) is a service(s) performed in addition to the primary service as determined by the Claims Administrator. The Allowable Charge for the 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 the incidental service(s). If the primary service is not covered, any incidental service(s) will not be covered.

d. Unbundled Service(s)

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

(2) The Allowable Charge of the comprehensive 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 Service(s)

(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. 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. Mutually exclusive services are two (2) or more services that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made. One 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 service(s), which are not considered Medically Necessary will not be covered.

3. Assistant Surgeon

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

4. Anesthesia

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

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

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

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

5. Second Surgical Opinion

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

B. Inpatient Medical Services

Subject to provisions in the sections 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 is determined 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 shown below. Refer to Your Schedule of Benefits to see which Prescription Drug Benefit applies to You.

A. The Prescription Drugs must be dispensed on or after the 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 in 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 the negotiated amount and it is used to base the Plan's payment for the Plan Participant's covered Prescription Drugs.

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

C. The Plan Participant should present his ID card to the pharmacist when purchasing covered Prescription Drugs at a Participating Pharmacy. The Prescription Drug Deductible, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. If the Plan Participant has not met his Prescription Drug Deductible, the Participating Pharmacy may collect one hundred percent (100%) of the discounted costs of the drug at the point of sale. If the Plan Participant has met his Prescription Drug Deductible, he will pay the Copayment or Coinsurance percentage 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 uses a closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Benefit Plan. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost 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 to Plan Participants in several ways. Most Plan Participants receive information by accessing the pharmacy section of the Claims Administrator's website, www.bcbsla.com/pharmacy or request a copy by mail by calling the Pharmacy Benefit Manager at the telephone number indicated on the Plan Participant's ID card.

   Plan Participants may also contact the Claims Administrator at the telephone number on their 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 Plan Participant's prescribing healthcare Provider will prescribe the drug for a particular medical condition or Mental Illness.

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 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 drug review request is not approved, the Plan Participant may file an internal or external drug review request to the Claims Administrator.

Option 1 – Prescription Drug Benefits – Four Tier

1. The Prescription Drug Deductible, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Plan Participant may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Plan Participant may be required to pay a different Copayment or Coinsurance depending on whether the Plan Participant's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.

2. The Prescription Drug Copayment or Coinsurance is based on the following tier classifications shown in the Schedule of Benefits. Tier placement is based on the Claims Administrator's evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. Plan Participants may call customer service or go to **www.bcbsla.com/pharmacy** to identify the tier classification of their Prescription Drug.

3. 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 Tier 3 if it is a non-Specialty Drug and at Tier 4 if it is a Specialty Drug.

   Tier 1 - Value Drugs: Primarily Generic Drugs, although some Brand-Name Drugs may fall into this category.

   Tier 2 – Brand-Name Drugs

   Tier 3 - Primarily Brand-Name Drugs that may have a therapeutic alternative that is in Tier 1 or Tier 2, although some Generic Drugs may fall into this category.

   Covered compounded drugs are included in this Tier.

   Tier 4 - Specialty Drugs: High-cost Brand-Name Drugs or Generic Drugs that are identified as Specialty Drugs.

Option 2 – Prescription Drug Benefits - Two Tier

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

2. 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.

Tier 1 - Generic Drugs

Tier 2 - Brand-Name Drug

Option 3 – Prescription Drug Benefits - Three Tier

1. The Prescription Drug Deductible, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Plan Participant may be required to pay a different Copayment or Coinsurance depending on whether the Plan Participant's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.

2. The Prescription Drug Copayment or Coinsurance is based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on the Claims Administrator's evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. Plan Participants may call customer service or go to **www.bcbsla.com/pharmacy** to identify the tier classification of their Prescription Drug.

3. If a drug review request is approved, Plan Participants will receive coverage for the drug that is not on the Prescription Drug Formulary at the highest drug tier (Plan Participant cost share amount).

   Tier 1 - Primarily Generic Drugs (traditional and specialty), although some Brand-Name Drugs may fall into this category.

   Tier 2 - Includes traditional brands and generics, specialty brands and generics, and biosimilars.

   Tier 3 - Includes traditional brands and generics, specialty brands and generics, biosimilars, and covered compound drugs.

E. The Claims Administrator's Prescription 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 Plan Participant's ID Card. If the Prescription Drug requires prior Authorization, the Plan Participant's Physician must call the medical Authorization telephone number on the Plan Participant's ID Card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.

   2. Safety checks – Before the Plan Participant's prescription is filled, the Claims Administrator's Pharmacy Benefit Manager or the Claims Administrator 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 Plan.

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 Plan will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Plan Participant's medical condition, the Plan Participant's Physician may be required to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Plan will cover a prescription written for Drug B. However, if 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, he will be responsible for the full cost of the drug.

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

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

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

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

F. 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 the Claims Administrator's Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that it dispenses, the Allowable Charge is the negotiated amount that Participating Pharmacies have agreed to accept for drugs dispensed.

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

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

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.

J. 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 Claims Administrator's Pharmacy Benefit Manager at the telephone number indicated on His ID card or refer to His 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 Preventive or Wellness Care services from a Network Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge. When Preventive or Wellness Care services are rendered by a Non-Network Provider, Benefits will be subject to Copayment amounts (if applicable) and Coinsurance percentages shown in the Schedule of Benefits. The Deductible Amount will apply to Covered Services received from a Non-Network Provider, unless otherwise stated below.

Preventive or Wellness Care services may be subject to other limitations shown in the Schedule of Benefits.

A. Well Woman Examinations

1. Routine annual visits to an obstetrician or gynecologist. Additional visits recommended by the Plan Participant's obstetrician/gynecologist may be subject to the Deductible Amount, Copayment or Coinsurance percentage shown in the Schedule of Benefits, if not a preventive service.

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

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

B. Physical Examinations

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

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

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

3. Prostate Cancer Screening – One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, is covered for 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. The Benefit Period Deductible does not apply.

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

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

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

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

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

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

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

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

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

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

The list of covered services changes from time to time. To check the current list of recommended Preventive or Wellness Care services required by PPACA, visit the United States Department of

Health and Human Services' website at: **http://www.healthcare.gov/preventive-care-benefits/** or contact our Customer Service Department at the telephone number on your ID card.

D. New Recommended Preventive or Wellness Care Services

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

E. COVID-19 Services

Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by a Member's Physician for the purpose of making clinical decisions or treating a Member suspected of having COVID-19 are covered under this Plan. When a Member receives these services from a Network or Non-Network Provider, Benefits will be covered, up to the Network allowable, at no cost until December 31, 2021, or as required by applicable federal law. Non-Network Providers are able to balance bill the Member up to their full-billed charge. Balance bills do not apply to the Out-of-Pocket Maximum. After December 31, 2021, this Plan may pay according to the Contract Benefits, subject to applicable Copayments, Deductibles, and Coinsurance Amounts, as shown on the Schedule of Benefits for Network or Non-Network Providers.

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

ARTICLE IX. MENTAL HEALTH BENEFITS

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

B. The first follow-up visit after discharge from an Inpatient facility for the treatment of a Mental Disorder or a substance use disorder is available at no cost to the Plan Participant when performed within seven (7) days of the discharge by a Network Provider approved by the Claims Administrator as a behavioral health Provider. Additional visits will be paid subject to contract Benefits.

ARTICLE X. SUBSTANCE USE DISORDER BENEFITS

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

B. The first follow-up visit after discharge from an Inpatient facility for the treatment of a substance use disorder is available at no cost to the Plan Participant when performed within seven (7) days of the discharge by a Network Provider approved by the Claims Administrator as a behavioral health Provider. Additional visits will be paid subject to contract Benefits.

ARTICLE XI. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, Providers in the HMOLA Network, the United Concordia Dental Network (Advantage Plus), or Blue Cross and Blue Shield of Louisiana's dental network are considered Network Providers. Access these Networks online at **www.bcbsla.com** or call the customer service telephone

number on Your ID card for copies 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 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 determine if the Plan Participant is eligible for these Benefits, please call the Claims Administrator's customer service department at the phone number on the Plan Participant's ID card and ask to speak to a Case Manager.

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

ARTICLE XII. ORGAN, TISSUE, AND BONE MARROW TRANSPLANT BENEFITS

(Network Category Only)

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

SOLID ORGAN AND BONE NARROW TRANSPLANTS WILL NOT BE COVERED UNLESS THE PLAN PARTICIPANT OBTAINS WRITTEN AUTHORIZATION FROM THE CLAIMS ADMINISTRATOR PRIOR TO SERVICES BEING RENDERED. THE PLAN PARTICFIPAN OR HIS PROVIDER MUST ADVISE THE CLAIMS ADMINISTRATOR OF THE PROPOSED TRANSPLANT PROCEDURE PRIOR TO ADMISSION AND A WRITTEN REQUEST FOR AUTHORIZATION MUST BE FILED WITH THE CLAIMS ADMINISTRATOR. THE PLAN MUST BE PROVIDED WITH ADEQUATE INFORMATION SO THAT THE CLAIMS ADMINISTRATOR MAY VERIFY COVERAGE, DETERMINE THAT MEDICAL NECESSITY IS

DOCUMENTED, AND APPROVE OF THE HOSPITAL AT WHICH THE TRANSPLANT PROCEDURE WILL OCCUR. THE CLAIMS ADMINISTRATOR WILL FORWARD WRITTEN AUTHORIZATION TO THE PLAN PARTICIPANT AND TO THE PROVIDER(S).

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplant Benefits

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

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

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

4. 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

        (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)

        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.

These following tissue transplants are covered:

(1) blood transfusions;

(2) autologous parathyroid transplants;

(3) corneal transplants;

(4) bone and cartilage grafting;

(5) skin grafting;

(6) autologous islet cell transplants; and

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

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

Pregnancy Care as described in this Article of the Benefit Plan is covered only if shown as covered in the Schedule of Benefits. If Pregnancy Care is not covered, complications of pregnancy are not covered, except for ectopic pregnancies and spontaneous abortions (miscarriages). Benefits for treatment of ectopic pregnancies and spontaneous abortions are available for all covered Plan Participants under the Hospital Benefits and Medical and Surgical Benefits articles of this Benefit Plan.

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

We have several maternity programs available to help pregnant Plan Participants deliver healthy babies. Please call Our Customer Service Department at the number on the back of Your ID card when You learn You are having a baby. When You call, We'll let You know what programs are available to You.

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

A. Pregnancy Care

1. Medical and Surgical Services.

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

   b. Diagnostic Services.

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

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

2. Facility Services

   Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for well-baby care 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.

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

4. Benefits

   a. Network Benefits: A Pregnancy Care Copayment, if shown in the Schedule of Benefits, applies to each pregnancy for Covered Services rendered by Network Providers. The Plan Participant must pay an Inpatient Hospital Admission Copayment for any hospitalization related to the pregnancy, as shown in the Schedule of Benefits, in addition to the Pregnancy Care Copayment. An In-Network Deductible and Coinsurance may apply to some plans, if shown in the Schedule of Benefits.

   b. Non-Network Benefits: The Plan Participant must pay the Inpatient Hospital Admission Coinsurance and Pregnancy Care Coinsurance if shown in the Schedule of Benefits, in addition to the applicable Deductible Amount. A Non-Network Deductible and Coinsurance may apply to some plans, if shown in the Schedule of Benefits.

B. Newborn Care

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

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

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

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

2. For a newborn who is covered at birth as a Dependent.

   a. Surgical and medical services rendered by a Physician, for treatment of illness, prematurity, postmaturity, or congenital condition of a newborn and circumcision. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.

      (1) Network Benefits: The Plan Participant must pay all applicable Deductibles, Coinsurance and Copayments as shown in the Schedule of Benefits.

      (2) Non-Network Benefits: Benefits for services of a Physician for treatment of a newborn will be determined by applying any applicable Deductible and Coinsurance to Allowable Charges for Covered Services.

   b. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, prematurity, postmaturity, or congenital condition of a newborn. Charges for services for a well newborn, including the Hospital (nursery) charge, should not be billed separately from the mother's Hospital bill.

      (1) 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.

      (2) Network Benefits: An Inpatient Hospital Admission Copayment applies to the Admission of an ill newborn for treatment in a Hospital. We will provide Benefits of one hundred percent (100%) of the Allowable Charges for such treatment, less the Plan Participant's Copayment. An In-Network Deductible and Coinsurance may apply to some plans, if shown in the Schedule of Benefits.

      (3) Non-Network Benefits: Benefits for Hospital Covered Services for treatment of an ill newborn will be determined by applying the Coinsurance shown in the Schedule of Benefits to Allowable Charges for those services. A Non-Network Deductible and Coinsurance may apply to some plans, if shown in the Schedule of Benefits.

ARTICLE XIV. HABILITATIVE/REHABILITATIVE CARE BENEFITS

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

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

A. Occupational Therapy

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

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

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

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

B. Physical Therapy

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

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

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

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

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

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

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

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

    e. to an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider rendering the

diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

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

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

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

D. Chiropractic Services

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

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

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

ARTICLE XV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. 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 or from 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 medical conditions that do no present an emergency to obtain Medically Necessary Inpatient or Outpatient services when the Plan Participant is bed-confined or his condition is such that the use of any other method of transportation is contraindicated. Benefits for non-Emergency transport are only available for transport to or from the nearest facility or Hospital capable of providing the Medically Necessary services.

The 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. For Emergency Medical Conditions, the air Ambulance Service must be specifically requested by police or medical authorities present at the site with the Plan Participant in order for air Ambulance Services to be covered.

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

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

b. Non-Emergency Transport

If Authorized by Us before services are rendered, Benefits for non-Emergency air Ambulance Services are available for Members, to the nearest facility or Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care. Once Authorized, you should verify the Network participation status of the air Ambulance

Service Provider in the state or area the pick-up is to occur, based on zip code. To locate a Network Provider in the state or area where you will be receiving services, please go to the Blue National Doctor & Hospital Finder at **http://provider.bcbs.com** or call 1-800-810-2583.

4. Ambulance Service Benefits will be provided as follows:

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

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

   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 (ASD)

ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Habilitative and Rehabilitative 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.

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

E. Breast Reconstructive Surgery 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 resulting from breast cancer and elects breast reconstruction will also receive Benefits for the following Covered Services:

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

   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 mastectomy, including lymphedemas.

These Covered Services shall be delivered in a manner determined in consultation with the attending Physician and the Plan Participant and, if applicable, will be subject to any Deductible, Copayment and Coinsurance.

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

a. were previously diagnosed with breast cancer;

b. completed treatment for breast cancer;

c. underwent bilateral mastectomy; and

d. were subsequently determined to be clear of cancer.

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

F. Cleft Lip and Cleft Palate Services

The following services for the 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.

9. Genetic assessment and counseling for patient and parents.

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

G. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other Life-Threatening Illness. Coverage will be subject to any applicable

terms, conditions and limitations that apply under this Benefit Plan, including Copayment, Deductible, or Coinsurance amounts shown in the Schedule of Benefits.

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

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

   b. and either,

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

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

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

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

      (1) The National Institutes of Health.

      (2) The Centers for Disease Control and Prevention.

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

      (4) The Centers for Medicare & Medicaid Services.

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

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

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

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

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

      (1) The Department of Veterans Affairs.

      (2) The Department of Defense.

(3) The Department of Entergy.

4. The following services are not covered:

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

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

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

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

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

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

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

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

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

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

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

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

H. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

   a. 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 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 contract benefits

I. Dietitian Visits

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

J. Disposable Medical Equipment and Supplies

Disposable medical equipment or 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 and Coinsurance.

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered at the Deductible and Coinsurance percentages 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 Plan's option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.

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

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

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

(6) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or replacement of equipment damaged due to neglect or misuse will not be covered. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Benefit Plan, will not be covered.

c. Limitations in connection with Durable Medical Equipment.

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

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

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

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

2. Orthotic Devices

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

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

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

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

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

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

3. Prosthetic Appliances and Devices (Non-Limb)

   Benefits will be available for the purchase of Prosthetic Appliances and Devices (other than limb prosthetics and services) that is 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 or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Plan will determine this time period.

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

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

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

   Benefits will be available for the purchase of Prosthetic Appliances and Devices and Prosthetic Services of the limbs that 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 Plan will determine this time period.

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

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

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

L. Emergency Medical Services

1. Hospital Facility Services

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

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

2. Professional Services

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

M. Gene Therapy and Cellular Immunotherapy Benefits

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

N. Hearing 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 hearing aid, per ear, in a thirty-six (36) month period. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or a hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

   The Plan will pay up to the Allowable Charge for this Benefit. The Plan may increase their Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge.

2. Implantable bone conduction hearing aids, cochlear implants and bone-anchored hearing aids (BAHA) are covered for all eligible Members, regardless of age, for all eligible Members, regardless of age, the same as any other service or supply, subject to Medical Necessity and payment of applicable Copayments, Coinsurance and Deductible Amounts.

O. High-Tech Imaging

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

P. Home Health Care

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

Q. Hospice Care

Hospice Care is covered.

R. Interpreter Expenses for the Deaf or Hard of Hearing

Services of a qualified interpreter/transliterator are covered when the Plan Participant needs such services in connection with medical treatment or diagnostic Consultations if the services are required because of a Plan Participant's hearing loss or a language communication failure. These services are not covered if the services are rendered by a family member, or if the medical treatment or Consultation is not covered.

S. 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 specially 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

T. 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.

U. Permanent Sterilization Procedures and Contraceptive Devices

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

2. IUDs may be available, under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Preferred Provider.

V. 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.

W. Private Duty Nursing Services

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

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

3. Inpatient Private Duty Nursing Services are not covered.

X. Sleep Studies

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

Y. Telehealth Services

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

Interaction between Plan Participant and Provider may take place in different ways, depending on the circumstances. It must always be medically appropriate for the setting in which the 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.

The amount You pay for a Telehealth Services visit may be different than the amount You would pay for the same Provider's service in a non-Telehealth setting. You will pay more for a Telehealth visit when your Provider is not in your Network.

HMO Louisiana has the right to determine if billing was appropriate and contains the required elements for the Claims Administrator to process the Claim.

In general, there is no coverage for Telehealth 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 encounters supported by technology that is not HIPAA-compliant.

Telehealth Services and the Providers who can render those services are determined by the Claims Administrator.

Z. Temporomandibular Joint Syndrome (TMJ)

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

AA. Urgent Care Center Benefits

Services of Urgent Care Centers are covered.

ARTICLE XVI. CARE MANAGEMENT

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

1. Selection of Provider

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

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

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

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

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

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

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

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

   a. Admissions

      (1) If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This

penalty applies to all covered Inpatient charges. The Network Provider or Participating Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Copayment or his Deductible and Coinsurance percentage shown in the Schedule of Benefits.

(2) If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown in the Schedule of Benefits. This penalty applies to all covered Inpatient charges.

The Plan Participant is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage shown in the Schedule of Benefits.

b. Outpatient Services, Other Covered Services and Supplies

(1) If a Network Provider fails to obtain a required Authorization, We may reduce the Allowable Charge by thirty percent (30%). This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for his Copayment or Deductible and applicable Coinsurance percentage.

(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 remains responsible for his Copayment, Deductible and applicable Coinsurance percentage.

3. Authorization of Admissions

a. Authorization of Elective Admissions

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

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

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

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

b. Authorization of Emergency Admissions

It is the Plan Participant's responsibility to ensure that his Physician or Hospital, or a representative thereof, notifies the Company's Care Management Department of all

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

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

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

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

c. Concurrent Review

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

(1) If We do 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 We receive and Authorize another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and We determine that it is not Medically Necessary for the Plan Participant to receive continued hospitalization or hospitalization at the level of care requested, We will notify the Plan Participant and his Providers, in writing, that the request is denied and no additional days are Authorized.

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

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

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

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

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

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

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

B. Disease Management

1. Qualification

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

2. Disease Management Benefits

   HMO Louisiana Inc.'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 life style modification, and improve adherence to their Physician prescribed treatment plan. HMO Louisiana Inc. is dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant.

C. Case Management

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

   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.

2. 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.

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

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

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

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

D. Alternative Benefits

1. The Plan Participant may qualify for Alternative Benefits, at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment.

   The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Plan Participant and to the Group.

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

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

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

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

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

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

ARTICLE XVII. LIMITATIONS AND EXCLUSIONS

A. Benefits for conditions, services, Surgery, supplies and treatment for services that are not covered under this 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 of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown in the Schedule of Benefits.

D. Unless otherwise shown as covered in 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 policy. 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 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 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 Workers' Compensation Law subject to the provisions of La. R.S. 23:1205(C), whether or not coverage under such law is actually in force;

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

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 You and Your Provider unless specifically stated as covered under the Telehealth Services Benefit Services billed with Telehealth codes not medically appropriate for the setting in which the services are provided. Telehealth Services rendered by Providers not Authorized by the Claims Administrator;

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

k. for services performed in the home unless the services meet the definition of Home Health, or otherwise covered specifically in this policy, or are approved by the Claims Administrator; or

l. for paternity tests and test 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. for treatment of any Plan Participant detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention; or

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

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

a. rhinoplasty;

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

c. gynecomastia;

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

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

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

g. diastasis recti;

h. biofeedback;

i. lifestyle/habit changing clinics and/or programs; except those the law requires Us to cover and those offered, endorsed, approved, or promoted by the Claims Administrator, which may be part of your healthcare coverage under this Benefit Plan. Some of these programs may be offered as value-added programs and may be subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the programs;

j. Diabetes prevention programs unless approved by Us 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 Us as Medically Necessary for the treatment of mental health conditions or substance use disorders;

l. treatment related to erectile 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; except services required to be covered by law;

n. recreational therapy;

o. primarily to enhance athletic abilities; and/or

p. Inpatient pain rehabilitation and Inpatient pain control programs.

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

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

b. eye exercises, visual training, or orthoptics;

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

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

e. 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;

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

   e. 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 Claims Administrator prior to services being rendered.

9. **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, regardless of Medical Necessity, except as required by law.

10. **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 as described in this Benefit Plan.

11. 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 in the Schedule of Benefits:

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

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

c. Investigational drugs and drugs used other than for the FDA approved indication along with all Medically Necessary services associated with the administration of the drug, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals or the drug is expected to provide a similar clinical outcome for the covered indication as those included in nationally accepted standards of medical practice as determined by Us;

d. fertility drugs;

e. nutritional or dietary supplements, or herbal supplements and treatments, except those required to be covered by the United States Preventive Services Task Force preventive services recommendations;

f. prescription vitamins not listed as covered in the drug formulary (including but not limited to Enlyte);

g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter (OTC) drugs, except those required to be covered by law;

h. selected Prescription Drugs for which there is an OTC-equivalent or for which a similar alternative exists as an OTC medication;

i. 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;

j. 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 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;

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

l. selected Prescription Drug products that contain more than 1 active ingredient (sometimes called combination drugs);

m. Prescription Drug products that include or are packaged with a non-Prescription Drug product are excluded;

n. Prescription Drug compounding kits are excluded;

o. selected Prescription Drug products that are packaged in a way that contains more than one Prescription Drug;

p. Prescription Drug products that contain marijuana, including medical marijuana;

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

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

s. 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;

t. growth hormone therapy, except for the treatment of chronic renal insufficiency, AIDS wasting, Turners 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; or

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

v. 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;

w. topically applied prescription preparations that are approved by the FDA as medical devices;

x. Prescription Drugs subject to the Step Therapy program when the Step Therapy program was not utilized or the drug was not approved by Us or Our Pharmacy Benefit Manager;

y. 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.

z. 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 BCBSLA are covered under the medical benefit and excluded under the pharmacy benefit; and

aa. sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Plan Participant's Coinsurance and the Plan's financial responsibility. The Plan will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the

total Prescription Drug Cost is less than the Plan Participant's Copayment, in which case, the Plan Participant must pay the Prescription Drug cost and sales tax.

12. **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, personal fitness equipment, or alterations to a Plan Participant's home or vehicle.

13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for routine foot care; palliative or cosmetic care or treatment; 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.

14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any abortion other than to save the life of the mother.

15. **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.

16. **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.

17. **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.

18. **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

19. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child.

20. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for anesthesia by hypnosis, or charges for anesthesia for non-covered services.

21. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for acupuncture when used to provide treatment for a condition or service that is excluded from coverage under this Benefit Plan.

22. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Cosmetic Surgery, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly or Mastectomy. Complications resulting from any of these or any other non-covered items are excluded.

23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits. This exclusion does not apply to cleft lip and cleft palate coverage.

24. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to. malocclusion, hyperplasia and 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 coverage.

25. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.

26. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for travel expenses of any kind or type other than covered Ambulance Services to the closest hospital equipped to adequately treat the Plan Participant's condition, except as specifically provided in this Benefit Plan, or as approved by the Claims Administrator.

27. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Repatriation of remains from an international location back to the United States is not covered. Private or commercial air or sea transportation is not covered. Plan Participants traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to your home country and air/sea travel when ambulance is not required

28. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This includes Applied Behavior Analysis (ABA) services that are not habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or custodial care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law.

29. Benefits are excluded for Applied Behavior Analysis (ABA) that We determined is not Medically Necessary. The following are also excluded: ABA rendered to Members age twenty-one (21) and older; ABA rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state and; Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders

30. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician's office.

31. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Custodial Care, nursing home or custodial home care, regardless of the level of care required or

provided. This exclusion for custodial care does not apply to Habilitative Care services that are required to be covered by law.

32. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for hospital charges for a well newborn, except as specifically provided in this Benefit Plan.

33. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care of when required by law.

34. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for medical and surgical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).

35. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for reversal of a voluntary sterilization procedure.

36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by the Claims Administrator. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by the Claims Administrator.

37. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for the prophylactic storage of cord blood.

38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for sleep studies, unless performed as a home sleep study or in a network-accredited sleep laboratory. If a sleep study is not performed as a home sleep study, not performed by a network-accredited sleep laboratory, or a sleep study is denied, then neither the sleep study nor any professional claims associated with the sleep study are eligible for coverage.

ARTICLE XVIII. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

1. If eligibility for Group coverage ceases upon the death of the Employee, 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 Employee's death to notify the Plan of his election to continue the same coverage for himself, and if already covered, for his Dependent children.

    a. Coverage is automatic during the ninety (90) day election period. Fees are owed for this coverage. If continuation is not chosen, or if fees 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.

    If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Fees are owed from the last date for which fees have been paid. No physical exams are required. Fees for continuing coverage will not exceed the fees assessed for each Employee by class of coverage under the Plan.

The Plan Administrator will be responsible for notifying the Spouse of the right to continue and for billing and collection of fees or contributions towards the cost of coverage. However, if the Claims Administrator has been furnished with the home address of the surviving Spouse at the time of death and has been notified by the Plan Administrator in an acceptable manner of the death of the Employee, the Claims Administrator will notify the surviving Spouse of the right to continue.

2. Coverage continues on a fee-paying basis until the earliest of:

   a. the date fees are due and not paid on a timely basis; or

   b. the date the surviving Spouse or a Dependent child becomes eligible for Medicare; or

   c. the date the surviving Spouse or a Dependent child becomes eligible to participate in another Group health plan; or

   d. the date the surviving Spouse remarries or dies; or

   e. the date this Plan ends; or

   f. the date a Dependent child is no longer eligible.

B. COBRA Continuation

The following provisions are applicable only if the Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto. Please refer to the Group's 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 his Dependent children are listed under the law as the qualified beneficiaries. COBRA continuation coverage offers the same coverage that the Plan gives to other Plan 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, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important

that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special enrollment opportunity for the Marketplace, and You will not be able to enroll until the Marketplace's normal enrollment period opens or Your COBRA continuation coverage is exhausted.

Additionally, You may qualify for a special enrollment opportunity for another group health plan for which You are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if You request enrollment within thirty (30) days from losing coverage under this Benefit Plan.

You should consider all Your options in order to choose the one that best fits Your needs and budget.

What if I choose to get COBRA continuation coverage?

If You and Your Dependents are qualified beneficiaries and choose to get COBRA continuation coverage, You must follow all notice and time period requirements described below or You will lose Your rights. If the Group requires shorter time periods than those stated herein, the shorter time periods of the Group apply.

What are the "qualifying events"?

A "qualifying event" is any of the following events:

- termination of employment of a covered Employee for reasons other than gross misconduct;
- loss of eligibility by a covered Employee due to a reduction in the number of work hours of the Employee;
- death of a covered Employee;
- divorce or legal separation between a covered Employee and his/her Spouse;
- the covered Employee becomes entitled to Medicare Benefits resulting in the loss of coverage for Dependents;
- a Dependent child ceases to be an eligible Dependent under the terms of this Benefit Plan; or
- the Employer files for a Chapter 11 bankruptcy proceeding, but only with respect to covered former Employees who retired from the Employer at any time.

NOTE: Special rules apply for certain retirees and their Dependents who lose coverage because of an employer's Chapter 11 bankruptcy. In this event, certain retirees may elect lifetime COBRA coverage. Eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including but not limited to: the employer ceases to provide any group health plan to any employees or the qualified beneficiaries fail to pay the required premiums or become covered under another employer's group health plan that does not exclude or limit Benefits for a qualified beneficiary's Pre-Existing Conditions. COBRA continuation coverage rights under Chapter 11 bankruptcy proceedings will be determined by the bankruptcy court, and the coverage eligible beneficiaries could receive may not be the same as the ones they had under the retiree plan before the employer filed for Chapter 11 bankruptcy.

Do I have to provide notification of any qualifying event?

The qualified beneficiary must give notice of the following qualifying events to the Group within 60 days of the event:

- divorce or legal separation,
- becoming entitled to Medicare, or
- a Dependent losing eligibility for coverage as a Dependent child.

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

What do I have to do to get COBRA continuation coverage?

To elect continuation coverage, the qualified beneficiary must complete a COBRA election form and furnish it to the Group timely. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Plan Participant would otherwise lose coverage under the Group health plan (the "coverage end date"); and
- ends sixty (60) days after the coverage end date or sixty (60) days after the 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. Plan Participants may not receive notice of payments due.

When will COBRA continuation coverage begin and how long will it last?

Once elected, COBRA continuation of coverage will begin on the coverage end date and will terminate on the earliest of the following events:

- eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the Employee became entitled to Medicare benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified beneficiaries other than the Employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or

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

- the date the Employer ceases to maintain any Group health plan for its Employees; or

- the date coverage ceases because of nonpayment of required premiums when due; or

- the date the qualified beneficiary first becomes covered under another group health plan and benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (NOTE: There are limitations on plans imposing Pre-Existing condition exclusions and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).; or

- the date the qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

Can I extend my COBRA continuation coverage?

A qualified beneficiary's right to COBRA continuation coverage will never last longer than thirty-six (36) months from the qualifying event. This maximum duration period cannot be extended, regardless of the circumstances.

Those that are receiving eighteen (18) months of continuation coverage can extend their period, as explained below, if they undergo a second qualifying event or are declared disabled by the Social Security Administration during that original eighteen (18) month period.

If a qualified beneficiary experiences a second qualifying event other than the termination of employment or reduction of work hours while receiving eighteen (18) months of COBRA continuation of coverage, the Dependents who were qualified beneficiaries at the time of the first qualifying event, and elected COBRA continuation coverage, may qualify for up to eighteen (18) additional months of continuation of coverage, for a maximum of thirty-six (36) months. This extension may be available to Dependents receiving continuation of coverage if:

- the Employee or former Employee dies;

- the Employee or former Employee becomes entitled to Medicare (under Part A, Part B, or both);

- the Employee or former Employee and Dependent Spouse divorce;

- the Dependent child is no longer eligible under the Benefit Plan as a Dependent.

The second qualifying event is applicable only if the event would have caused the Dependent to lose coverage under the plan had the first qualifying event not occurred. Qualified beneficiaries must notify the Group within sixty (60) days after the date of a second qualifying event to extend the COBRA continuation coverage.

The eighteen (18) months of continuation coverage may also be extended to a maximum of twenty-nine (29) months if a qualified beneficiary is disabled at some time during the first sixty (60) days of COBRA coverage and is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) by the Social Security Administration during the original eighteen (18) months of COBRA coverage.

This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries and elected COBRA continuation coverage for the original eighteen (18) months. The qualified beneficiary must notify the Group of the disability determination before the end of the initial eighteen (18) month COBRA period and within sixty (60) days from the date of the notice from the Social Security Administration of 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 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 24 months from the date that the employee leaves for service. Only a covered employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the Plan immediately before him/her leaving for military service.

Dependents do not have any independent right to elect USERRA continuation coverage.

To claim USERRA continuation coverage, the employee must properly notify the employer that he/she is leaving to perform "service in the uniformed services" and apply for continuation coverage as required by the employer.

An employee who elects USERRA continuation coverage may be required to pay a premium. If the leave of absence lasts thirty (30) days or less, the person may be required to pay the employee's required contribution for coverage. However, if the military leave of absence lasts more than thirty (30) days, the person may be required to pay up to 102% of the full contribution under the Plan (including both, the employer's and the employee's contribution for coverage).

USERRA continuation coverage may be terminated before the maximum 24-month period if:

1. The employee fails to pay the required premiums timely, or

2. The day after the date on which the employee is required under the law to apply for or return to a position of employment and fails to do so.

Employers subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may choose to provide USERRA continuation coverage rights concurrently with COBRA continuation coverage, as allowed by law. Each employer acts independently in choosing how to apply this provision and is not reflective of any guidelines issued from BCBSLA. In all cases, the employer should be consulted on how this provision applies to their employer group sponsored plan.

Please contact your employer to ask for more details on how USERRA and other continuation coverage rights apply to You.

ARTICLE XIX. COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits ("COB") section applies to the Plan when a Plan Participant has healthcare coverage under more than one Plan. "Plan" is defined below.

2. This section is intended to describe the Order of Benefit Determination Rules that 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 policy terms without regard to 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 100% of the total Allowable Expense.

B. Definitions (Applicable only to this Article of this Benefit Plan)

1. "Allowable Expense" means any healthcare service or expense, including Deductibles, Coinsurance or Copayments, that is covered in full or at least in part by any Plan covering the Plan Participant.

   a. 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.

   b. An expense or a portion of an expense that is not covered by any of the Plans is not an Allowable Expense.

   c. The following are examples of expenses that are not Allowable Expenses.

      (1) If a Plan Participant 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.

      (2) If a Plan Participant 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 by the Provider in excess of the highest reimbursement amount for a specified Benefit is not an Allowable Expense.

      (3) If a Plan Participant 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.

   d. The following are examples of expenses that are Allowable Expenses.

      (1) If a Plan Participant 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 shall be the Allowable Expense for all Plans.

      (2) The amount of any Benefit reduction by the Primary Plan because a covered Plan Participant has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

2. "Closed Panel Plan" a Plan that provides health Benefits to covered Plan Participants 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 Provision" the part of the Benefit Plan providing the healthcare Benefits to which the COB Provision applies, and 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 Plan. A 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 child by a court decree; or

   b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

5. "Order of Benefit Determination Rules" determine whether this Plan is a Primary Plan or Secondary Plan when the Plan Participant has healthcare coverage under more than one Plan. When this Plan is primary, it determines payment for its Benefits first before those of any other plan without considering any other Plan's Benefits. When this Plan is secondary, it determines its Benefits after those of another plan and may reduce the Benefits it pays so that all Plan Benefits do not exceed 100% of the total Allowable Expense.

6. *"*Plan" is any of the following that provides Benefits or services for medical or Dental Care and Treatment. If separate Benefit Plans are used to provide coordinated coverage for Members of a group, the separate Benefit Plans are considered parts of the same Plan and there is no COB among those separate Benefit Plans.

   a. Plan includes:

      (1) Group Benefit Plans and non-group Insurance Contracts;

      (2) Health Maintenance Organization (HMO);

      (3) group and non-group coverage through Closed Panel Plans;

      (4) Group-Type Benefit Plans (whether insured or uninsured);

      (5) the medical care components of long-term care contracts, such as skilled nursing care;

      (6) the medical Benefits under group or individual automobile contracts; and

      (7) Medicare or 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 LSA-R.S. 22:1000 A.3C;

(6) Benefits provided in long-term care insurance policies for non-medical services;

(7) Medicare supplement policies;

(8) a state plan under Medicaid; or

(9) coverage under other federal government plans, unless permitted by law.

Each Benefit Plan for coverage under a or b, listed 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.

C. Order of Benefit Determination Rules

1. When a Plan Participant 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 regard to the Benefits of under any other Plan.

      (1) Except as provided in Paragraph (2) below, a Plan that does not contain a Coordination of Benefits Provision that is consistent with this section is always primary unless the provisions of both Plans state that the complying Plan is primary.

      (2) 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 provides that the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. 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.

   b. A Plan may consider the Benefits paid or provided by another Plan in calculating payment of its Benefits only when it is secondary to that other Plan.

2. Each Plan determines its order of Benefits using the first of the following rules that apply:

   a. Non-Dependent or Dependent Rule. The Plan that covers the Plan Participant 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 Plan Participant as a Dependent is the Secondary Plan. However, if the Plan Participant is a Medicare Beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Plan Participant as a Dependent; and primary to the Plan covering the Plan Participant as other than a Dependent (e.g. a retired Employee); then the order of Benefits between the two Plans is reversed so that the Plan covering the Plan Participant as an Employee, Member, policyholder, Subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

   b. Dependent Child Covered Under More Than One Plan Rules. 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 rule 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 (2)(b)(1) above shall 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 (2)(b)(1) above shall 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 (2)(b)(1) or (2)(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 rule ins Subparagraph (2)(e) (Longer or Shorter Length in Coverage) 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 shall be determined by applying the birthday rule above in Subparagraph (2)(b)(1) to the Dependent child's parent(s) and the Dependent's Spouse.

c. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a Plan Participant as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same Plan Participant as a retired or laid-off Employee is the Secondary Plan. The same would hold true if a Plan Participant is a Dependent of an active Employee and that same Plan Participant is a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of

Benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) can determine the order of Benefits.

d. COBRA or State Continuation Coverage Rule. If a Plan Participant 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 Plan Participant as an Employee, Member, Subscriber or retiree or covering the Plan Participant 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 rule, and as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) determine the order of Benefits.

e. Longer or Shorter Length of Coverage Rule. The Plan that covered the Plan Participant as an Employee, Member, policyholder, Subscriber or retiree longer is the Primary Plan and the Plan that covered the Plan Participant the shorter period of time is the Secondary Plan.

f. Fall-Back Rule. If none of the preceding rules determine the order of Benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, this Plan will never pay more than it would have paid had it been the Primary Plan.

D. Effects on the Benefits of this Plan

1. When this Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will calculate the Benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its 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, the Secondary Plan shall credit to its Plan Deductibles, Coinsurance, Copayments and any amounts it would have credited to its Deductible in the absence of other healthcare coverage. In any event, this Plan will never pay more than it would have paid had it been the Primary Plan.

2. The difference between the Benefit payments that this Plan would have paid had it been the Primary Plan, and the Benefit payments that it actually paid or provided shall be recorded as a Benefit reserve for the covered Plan Participant and used by this Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each Claim is submitted, this Plan will:

   a. determine its obligation to pay or provide Benefits under its Benefit Plan;

   b. determine whether a Benefit reserve has been recorded for the covered Plan Participant; and

   c. determine whether there are any unpaid Allowable Expenses during that claims determination period.

3. If there is a benefit reserve, the Secondary Plan will use the covered Plan Participant's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

4. If a covered Plan Participant 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 shall not apply between that Plan and other Closed Panel Plans.

You may request a copy in either paper form or electronic form of Appendix C, which provides an explanation for Secondary Plans on the purpose and use of the benefit reserve and how Secondary Plans calculate Claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at **https://www.ldi.la.gov/docs/default-source/documents/legaldocs/regulations/reg32-appendixc.pdf?sfvrsn=24e14b52_0**.

E. Summary

This is a summary of only a few of the provisions of Your health 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 health 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 (COB) 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. Claims Administrator needs 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 Plan is Primary

   If Employee or a family member is covered under another Plan in addition to this one, this Plan 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, who is covered by Medicare, and you are not both retired;

   c. The Claim is for the healthcare expenses of your child who is covered by this 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 rule;

      (2) You are separated or divorced, and you have informed Us of a court decree that makes you responsible for the child's healthcare expenses; or

      (3) There is no court decree, but you have custody of the 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 Deductibles.

      (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 contract calls for. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) 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 your Plan has reduced its Benefit because you did not obtain pre-certification, 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 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 year. At the end of the year any balance is erased, and a freshbBenefit reserve begins for each Plan Participant the next year as soon as there are savings on their 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 Plan Participant. We need not tell, or get the consent of, any Plan Participant to do this. Each Plan Participant claiming Benefits under this 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 Plan. We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under this Plan. To the extent, such payments are made; they discharge Us from further liability. The term “payment made” includes providing Benefits in the form of

services, in which case the payment made will be deemed to be the reasonable cash value of any Benefits provided in the form of services.

H. Right of Recovery

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

1. the Plan Participants 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.

A. The Benefit Plan

1. Except as specifically provided herein, this Benefit Plan will not make the Claims Administrator liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations. 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 Plan Administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those specifically undertaken by Us herein. 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 due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or in the case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition. 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.

2. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or 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.

3. 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.

   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.

4. 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 Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

5. The Company 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 premium based on a Plan Participant's health status or a health status-related factor.

B. Section 1557 Grievance Procedure

HMO Louisiana, Inc. does not discriminate on the basis of race, color, national origin, sex, age or disability. HMO Louisiana, Inc. has adopted an internal grievance procedure providing for prompt resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator, who has been designated to coordinate the efforts of HMO Louisiana, Inc. to comply with Section 1557 at the following address:

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238
800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

If You believe You have been subjected to discrimination on the basis of race, color, national origin, sex, age or disability, You may file a grievance under this procedure. It is against the law for HMO Louisiana, Inc. to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date You become aware of the alleged discriminatory action.

A complaint must be in writing, containing Your name and address. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

The Section 1557 Coordinator will investigate the complaint. This investigation may be informal, but it will be thorough. You are encouraged to submit evidence related to Your complaint. The Section 1557 Coordinator will maintain the files and records of HMO Louisiana, Inc. relating to such grievances. To the extent possible, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

The Section 1557 Coordinator will issue a written decision on the grievance no later than 30 days after it is received.

You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within 15 days of receiving the Section 1557 Coordinator's decision. The Section 1557 Grievance Administrator shall issue a written decision in response to the appeal no later than 30 days after it is received.

The availability and use of this grievance procedure does not prevent You from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the United States Department of Health and Human Services, Office for Civil Rights. You can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

United States Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

HMO Louisiana, Inc. will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

C. Amending and Terminating the Benefit Plan

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

D. Identification Cards and Benefit Plans

The Claims Administrator will prepare an identification (ID) card for each covered Employee. The Claims Administrator will issue a Benefit Plan to the Group and print a sufficient number of copies of this Benefit Plan for the Group's covered Employees. At the direction of Group, the Claims Administrator will either deliver all materials to the Group for Group's distribution to the covered Employees, or the Claims Administrator will deliver the materials directly to each covered Employee. Unless otherwise agreed between the Group and the Claims Administrator, the Group has the sole responsibility for distributing all such documents to covered Employees.

E. Benefits 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 HMOLA Provider Network, will be given by Us to a Plan Participant who has begun a course of treatment by the Provider.

   b. A Plan Participant has the right to continuity of care applicable to the following provisions and subject to consent of the treating Provider:

      (1) In the event the Plan Participant has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth (24^{th}) week of pregnancy, the Plan Participant shall be allowed to continue receiving Covered Services through delivery and postpartum care related to the pregnancy and delivery.

      (2) In the event the Plan Participant has been diagnosed with a Life-Threatening Illness, the Plan Participant shall be allowed to continue receiving Covered Services until the course of treatment is completed, not to exceed three (3) months from the effective date of termination of the Provider's contractual agreement.

   c. 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 Plan Participant voluntarily chooses to change Providers.

      (3) The Plan Participant relocates to a location outside of the geographic service area of the Provider or the HMOLA Provider Network.

      (4) The Plan Participant's chronic condition only requires monitoring and is not in an acute phase of the condition.

F. Termination of a Plan Participant's Coverage

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

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

   a. The Employee's coverage and that of all his Dependents automatically, and without notice, terminates at the date of the termination date.

b. The coverage of the Employee's Spouse will terminate automatically, and without notice 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, the date the Dependent ceases to be an eligible Dependent.

d. Upon the death of an Employee, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if Employee contributions have been paid through that period the date that death occurred. 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 terminate all rights of the Plan Participant to Benefits under the terms of this Benefit Plan as of the effective date of such cancellation or termination. Group shall have the obligation to notify its Plan Participants and beneficiaries of such cancellation or termination. The Claims Administrator shall have 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 termination of a Plan Participant's coverage.

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

G. Filing of Claims

1. You must file all Claims within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than fifteen (15) months from the date services were rendered.

2. Most 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 his Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to the Claims Administrator, may require the signature of the dispensing pharmacist. The claim form should then be sent to the Claims Administrator's Pharmacy Benefit Manager, whose telephone number can be found on the Plan Participant's ID card.

H. Applicable Law

This Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law. This Plan is not subject to regulation by any state other than the State of Louisiana.

If any provision of this Benefit Plan is in conflict with any applicable statutes or regulations of the United States of America or the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute or regulation.

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

2. The Plan reserves the right to pay Preferred Providers directly instead of paying the Plan Participant.

L. Plan Participant/Provider Relationship

1. The choice of a Provider is solely the Plan Participant's.

2. The Claims Administrator and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. The Claims Administrator does not render Covered Services, but only makes payment, on behalf of the Plan, for Covered Services for which the Plan Participant receives. Neither the Plan nor the Claims Administrator will be held liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any Network Provider or in any Network Provider's facilities. The Plan and the Claims Administrator have no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.

3. The use or non-use of an adjective such as HMOLA 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 age sixty-five (65) or older, and each active Employee's Spouse age sixty-five (65) or older, may elect to have coverage under this Plan or under Medicare.

    a. Where such Employee or such Spouse elects coverage under this Plan, this Plan will be the primary payor of Benefits with the Medicare program the secondary payor.

    b. This Plan will not provide Benefits to supplement Medicare payments for Medicare eligible expenses for an active Employee age sixty-five (65) or older or for a Spouse age sixty-five

(65) or older of an active Employee where such Employee or such Spouse elects to have the Medicare program as the primary payor.

2. Under federal law, if an active employee under age sixty-five (65) or an active employee's dependent under age sixty-five (65) is covered under a group benefit plan of an employer with one hundred (100) or more employees and also has coverage under the Medicare program by reason of Social Security disability, the group benefit plan is the primary payor and Medicare is the secondary payor.

3. For persons under age sixty-five (65) who are covered under this Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Plan the secondary payor, except that during the first thirty (30) month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, this Plan will be the primary payor and Medicare the secondary payor.

4. When this Plan is the primary payor, it will provide regular Benefits for Covered Services.

   When this Plan is the secondary payor, it will provide Benefits based on the lesser of: the Medicare approved amount or Our Allowable Charge. When an Allied Provider or Physician is not required by Medicare to accept the Medicare approved amount as payment in full, the Plan will base Benefits on the lesser of: the Medicare approved amount plus Medicare's limiting charge, if applicable, or the Plan's Allowable Charge.

N. Notice

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

O. Job-Related Injury or Illness

The Group must report to the appropriate governmental agency any job-related injury or illness of an Employee where so required under the provisions of any legislation of any governmental unit. This Plan, with certain described exceptions, excludes Benefits for any services covered in whole or in part by Workers' Compensation laws and/or rendered as a result of occupational disease or injury, subject to the provisions of La. R.S. 23:1205(C). In the event Benefits are initially extended by the Plan and a compensation carrier or employer makes any type of settlement with the Employee, or with any person entitled to receive settlement where the Employee dies, or if the Employee's injury or illness is found to be compensable under law, the Employee must reimburse the Plan for Benefits extended or direct the compensation carrier to make such reimbursement. The Group will be entitled to such reimbursement even if the settlement does not mention or excludes payment for 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 Plan all amounts recovered by suit, settlement, or otherwise from any third party or the Plan Participant's insurer to the extent of the Benefits provided or paid under this Plan. The Plan's right to reimbursement comes first even if the Plan Participant is not paid for all of the Plan Participant's Claim for damages against the other person or organization or even if the payment the Plan Participant receives is for, or is described as for, the Plan Participant's damages other than 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 Plan paid for which a third party or insurer is responsible will not be reduced by the amount of the Plan Participant's costs. The Plan Participant shall hold in trust for the account of the Plan all amounts recovered, up to the total amount of Benefits paid. The Group appoints the Plan Participant as its representative for such limited purpose only.

3. The Plan Participant will take such action, furnish such information and assistance, and execute such papers as the Plan may be required to facilitate enforcement of the Plan's rights, and will take no action prejudicing the Plan's rights and interest under this Plan. The Plan and its designees have the right to obtain and review Plan Participant's medical and billing records, if the Plan or its designee determines in their sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits Article of this Benefit Plan.

4. The Plan Participant is required to notify the Plan of any Accidental Injury.

Q. Right of Recovery

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

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 Plan to the extent the veteran would be eligible for Benefits for such care or services from the Plan if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

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

S. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that the Claims Administrator is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue

Shield Plans, the "Association" permitting Blue Cross and Blue Shield of Louisiana and its subsidiaries and affiliates (collectively “Blue Cross and Blue Shield of Louisiana”) to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that the Claims Administrator 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 to the Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of the Claims Administration agreement.

T. Certificates of Creditable Coverage

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

U. 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 Prescription Drug coverage. 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 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 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. The regulations require Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage be provided to covered Medicare-eligible Plan Participants at the following times, or as otherwise directed by law:

   1. prior to the Medicare Part D Annual Coordinated Election Period;
   2. prior to an individual’s Initial Enrollment Period (IEP) for Medicare Part D (age in);
   3. prior to the Effective Date of coverage for new Medicare-eligible Employees that join this Benefit Plan;
   4. whenever Prescription Drug coverage under this Benefit Plan ends or changes so that it is no longer creditable or becomes creditable; and/or
   5. upon a Medicare beneficiary’s request.

2. The second disclosure requirement is for Groups to complete the *Online Disclosure to CMS Form* to report the Creditable Coverage status of their Prescription Drug Plan. The Disclosure should

be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a Prescription Drug Plan, or within 30 days after any change in Creditable coverage status. This requirement does not pertain to the Medicare beneficiaries for whom Groups are receiving the Retiree Drug Subsidy (RDS).

The Groups are those listed at 42 CFR 423.56(b) and includes, but is not limited to, Group health plans (this would mean the Plan Sponsor of those plans), Individual health insurance coverage, and Medicare Supplement plans.

As a service to our Groups, The Claims Administrator shall provide at least once per year to certain Medicare-eligible Plan Participants who have Prescription Drug coverage under this Benefit Plan, without charge, a written certification that their Prescription Drug coverage under this Benefit Plan is either creditable or non-creditable. Coverage is deemed creditable if it is at least as good as the standard Medicare Part D Prescription Drug Benefit. The Claims Administrator will provide these certificates to covered Group Plan Participants who are eligible for Medicare Part D based upon enrollment data provided to the Claims Administrator by the Group.

V. Out-of-Area Services

HMO Louisiana, Inc. ("HMOLA") has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever You obtain healthcare services outside of Our Service Area, the Claims for those services may be processed through one of these Inter-Plan Arrangements.

When You receive care outside HMOLA's Service Area and the service area of Blue Cross and Blue Shield of Louisiana, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

This point-of-service Benefit Plan covers healthcare services received outside of HMOLA's Service Area, but pays Non-Network Benefits at a lower level. As used in this section, "Out-of-Area Covered Services" includes most, but not all Covered Services obtained outside the geographic area We serve. Organ, tissue and bone marrow transplants obtained from Non-Network Providers will not be covered when processed through any Inter-Plan Arrangements, unless both the services and use of a Non-Network Provider are Authorized by HMOLA prior to You receiving these services.

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 Us to provide the specific service or services.

1. BlueCard® Program

   Under the BlueCard® Program, when You receive Out-of-Area Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard® Program enables You to obtain Out-of-Area Covered Services from a healthcare Provider participating with a Host Blue, where available. The Participating Provider will automatically file a Claim for the Out-of-Area Covered Services provided to You, so there are no claim forms for You to fill out. You will be responsible for obtaining any required Authorizations and payment of applicable Copayments, Deductible Amount and Coinsurance, as stated in Your Schedule of Benefits.

Emergency Medical Services: If You experience a medical Emergency while traveling outside the HMOLA Service Area, go to the nearest Emergency facility.

When You receive Out-of-Area Covered Services outside HMOLA's Service Area and the service area of Blue Cross and Blue Shield of Louisiana and the Claim is processed through the BlueCard® Program, the amount You pay for the Out-of-Area Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

- the billed charges for Your Out-of-Area Covered Services; or
- the negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price We have used for Your Claim because they will not be applied after a Claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, We will include any such surcharge, tax or other fee as part of the Claim charge passed on to You.

2. Non-Participating Providers Outside Our Service Area

   a. Plan Participant Liability Calculation

      When Out-of-Area Covered Services are provided outside of HMOLA's Service Area and the service area of Blue Cross and Blue Shield of Louisiana by Non-Participating Providers, the amount You pay for such services will normally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Out-of-Area Covered Services as set forth in Your Benefit Plan. Federal or state law, as applicable, will govern payments for Non-Network Emergency Medical Services.

   b. Exceptions

      In certain situations, We may use other payment methods, such as billed charges for Out-of-Area Covered Services, the payment We would make if the healthcare services had been obtained within Our Service Area, or a special negotiated payment to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider bills

and the payment We will make for the Out-of-Area Covered Services as set forth in Your Benefit Plan.

3. Blue Cross Blue Shield Global® Core

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard® service area"), You may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists You with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard® service area, You will typically have to pay the Providers and submit the Claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global® Core service center for assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing.

However, if You paid in full at the time of service, You must submit a Claim to receive reimbursement for Covered Services. You must contact Us to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

b. Outpatient Services

Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area will typically require You to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

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

When You pay for Covered Services outside the BlueCard® service area, You must submit a Claim to obtain reimbursement. For institutional and professional Claims, You should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of Your Claim. The claim form is available from Us, the Blue Cross Blue Shield Global® Core service center, or online at www.bcbsglobalcore.com. If You need assistance with Your Claim submission, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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 You unable to perform Your 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 1,250 hours during the 12-month period preceding the leave requested.

   The Plan will continue coverage for Employee during any leave of absence the Group is required to provide by applicable federal or state law, including FMLA, the Americans with Disabilities Act or Pregnancy Discrimination Act, and any amendments or successor provisions, as long as eligibility criteria under the laws continues to be met. If Employee's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, 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 "Termination of a Plan Participant's Coverage."

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. 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 "Termination of a Plan Participant's Coverage."

X. Compliance with HIPAA Privacy Standards

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

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

1. General

   The Plan shall not disclose Protected Health Information to any 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

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

c. Resolution of Issues of Noncompliance. In the event that any Employee of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

(1) investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;

(3) mitigating any harm caused by the breach, to the extent practicable; and

(4) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Employer

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

a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Employer;

d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. ensure the adequate separation between the Plan and Employee of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

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 Article.

Z. Value-Added Programs

Insurer may from time to time provide Value-Added Services to the Group. These Value-Added Services may be provided to Group directly by Company, or indirectly by an affiliated life, health or disability insurance company, or by a third-party company. Value-Added Services are not considered Benefits under this Plan or any other policy of insurance. Plan Administrator is never under any obligation to accept Value-Added Services, and Claims Administrator may cease offering and paying for Value-Added Services at any time.

ARTICLE XXI. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The Claims Administrator wants to know when a Plan Participant is dissatisfied about the care or services they receive 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 and Grievance 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 processes for situations where the time frame of the standard medical Appeals would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function.

A. Complaint, Grievance, and Informal Reconsideration Procedures

A quality of service concern addresses the Plan's services, access, availability or attitude and those of the Claims Administrator's Network Providers. A quality of care concern addresses the appropriateness of care given to a Plan Participant.

1. To Register a Complaint

   A Complaint is an oral expression of dissatisfaction with Us or with Provider services. A quality of service concern addresses appropriateness of care given to a Member, Our services, access, availability or attitude and those of Our Network Providers.

   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.

2. To File a Formal Grievance

   A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Plan Participant does not feel his Complaint was adequately resolved or he wishes to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, the Plan Participant may call the customer service department.

   Send written Grievances to:

   HMO Louisiana, Inc.
   Appeals and Grievance Unit
   P. O. Box 98045
   Baton Rouge, LA 70898-9045

   A response will be mailed to the Plan Participant within thirty (30) business days 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 the 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 his 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 him in his Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent him in an internal or external 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 of Coverage, and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or Investigational.

   All Administrative Appeals should be submitted in writing to:

   HMO Louisiana, Inc.
   Appeals and Grievance Unit
   P. O. Box 98045
   Baton Rouge, LA 70898-9045

   a. First Level Administrative Appeals

      If a 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 the denial 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 considered 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 is determined to be experimental or Investigational and any related prospective or retrospective review determination.

All medical Appeals should be submitted in writing to:

HMO Louisiana, Inc.
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 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 their 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 on their Claim, the Plan Participant or their authorized representative must send their written request for an external Appeal, conducted by a non-affiliated Independent Review Organization (IRO), within one hundred twenty (120) days of receipt of the internal Appeal decision.

Requests submitted to the Claims Administrator after one hundred twenty (120) days 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 will be considered a final and binding.

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.

C. Expedited Appeals

The expedited Appeal process is available for review of the Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize the 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 service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the covered person's treating Physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Expedited Appeals are not provided for review of services previously rendered.

An Expedited Appeal shall be made available to, and may be initiated by the Plan Participant, his 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:

HMO Louisiana, Inc.
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

1. Expedited Internal Medical Appeals

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

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

ARTICLE XXII. CARE WHILE TRAVELING, MAKING PLAN CHANGES AND FILING CLAIMS

The Claims Administrator is continuing to update its online access for Plan Participants. Plan Participants may now be able to perform many of the functions described below, without contacting the Claims Administrator's customer service department. The Claims Administrator invites Plan Participants to log on to **www.bcbsla.com** for access to these services.

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of the Claims Administrator's local service offices, or from the home office of HMO Louisiana, Inc. If the Plan Participant needs to submit documentation to the Claims Administrator, the Plan Participant may forward it to HMO Louisiana, Inc. at P. O. Box 98024, Baton Rouge, LA 70898-9024, or to, 5525 Reitz Avenue, Baton Rouge, LA 70809.

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

A. How to Obtain Care While Traveling

The Plan Participant's ID card offers convenient access to 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 BlueCard® doctors and Hospitals.

3. Use a designated BlueCard® Provider to receive the highest level of Benefits.

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

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

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

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

Group may require the Employee to use the 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 so the Claims Administrator receives it within the timeframes set out in the Schedule of Eligibility, it is possible that the Employee's health benefits coverage will not be expanded to include the additional family members. Completing and returning a 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 explains when coverage becomes effective for new family members. Generally, a 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 should receive the Employee's completed form within thirty (30) days of the child's birth or placement, or the Employee's marriage.

C. How to File Claims for Benefits

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

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

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

1. an appropriate Claim form is used
2. the contract number (ID #) shown on the form is identical to the number on the ID card
3. the patient's date of birth is listed
4. the patient's relationship to the Employee is correctly stated
5. all charges are itemized, whether on the claim form or on the attached statement
6. the date of service (Admission to a Hospital or other Provider) or date of treatment is correct
7. the Provider includes a diagnosis and procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)
8. the Claim is completed and signed by the Plan Participant and the Provider.

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

D. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

   When a Plan Participant is being admitted to a HMOLA Provider or Participating Provider, the Plan Participant should show his HMO Louisiana, Inc. ID card to the admitting clerk. The Provider will file the claim with the Claims Administrator. The Plan's payments will go directly to the HMOLA Provider or Participating Provider. The Provider will then bill the Plan Participant directly for any remaining balance. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

2. Emergency Room or Outpatient Department Claims

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

3. Prescription Drug Claims

   Most Plan Participants with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Plan Participants who present an ID card to a Participating Pharmacist. However, if the Plan Participant must file a Claim to access his Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim form. 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 Claims Administrator's Pharmacy Benefit Manager, whose telephone number can be found on the Plan Participant's ID card.

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

4. Nursing Services Claims

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

5. Durable Medical Equipment (DME) Claims

   Charges for rental or purchase of wheelchairs, braces, crutches, etc. must be on the bill of the supplying firm, giving a description of the item rented or purchased, the date, the charge, and the patient's name.

   A statement from the attending Physician or Allied Health Provider that services were Medically Necessary must also be filed with these bills.

6. Mental Health and/or Substance Use Disorders

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

7. Other Medical Claims

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

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

   a. full name of patient

   b. date(s) of service

   c. description of and procedure code for service

   d. diagnosis code

   e. charge for service

   f. name and address of Provider of service.

E. If Plan Participant Has a Question about His Claim

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

HMO Louisiana, Inc.
5525 Reitz Avenue
Baton Rouge, LA 70898-9029

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

HMO Louisiana, Inc. has local service offices located in Baton Rouge, New Orleans and Shreveport.

ARTICLE XXIII. RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator

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.

E. The Claims Administrator is not a Fiduciary

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

ARTICLE XXIV. 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. A 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.

4. A complete list of employers or employee organizations sponsoring the Plan may be obtained by Plan Participants and beneficiaries upon written request to the Plan Administrator and is available for examination by Plan Participants and beneficiaries, as required by §§2520.104b-1 and §§2540.104b.

B. Continue Group Health Plan Coverage

An Employee may continue healthcare coverage for himself, his Spouse, or his Dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. The Employee or his 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 his employer, union or any other person, may fire him or otherwise discriminate against him in any way to prevent him from obtaining a Plan Benefit or exercising his rights under ERISA.

D. Enforce 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 to him 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 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 $110.00 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a Claim for Benefits, which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if he disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such 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 his rights, he may seek assistance from the United States Department of Labor, or he may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person he has sued to pay these costs and fees. If the Plan Participant loses, the court may order him to pay these costs and fees, for example, if it determines that his Claim is frivolous.

E. Assistance with Participant Questions

If a Plan Participant has any questions about his Plan, he should contact the Plan Administrator. If a Plan Participant has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Plan Participant may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XXV. 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 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)