NGF LARGE GROUP

PPO Group Care LADA

GROUP HEALTH BENEFIT PLAN

Louisiana

40HR1797 R01/22

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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 (WHCRA) ENROLLMENT NOTICE FOR ALL COVERED MEMBERS

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

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

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

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

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

If you have questions about this notice or about the coverage described herein, please contact our Customer Service Department at the number listed on the back of your ID card.

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NOTICES

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

For information about Network and Non-Network facility-based Physicians, go to **www.bcbsla.com** or call Customer Service at the number on Your ID card.

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

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

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

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

You do not need prior Authorization from Us or from any other person (including a Primary Care Physician) in order to have direct access to obstetrical or gynecological care from a healthcare professional in Your Network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior Authorization for certain services. For a list of Network healthcare professionals who specialize in obstetrics or gynecology, visit www.bcbsla.com or call the Customer Service phone number on Your ID card.

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

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

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

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

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

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

OPEN PRESCRIPTION DRUG FORMULARY

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

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

CLOSED PRESCRIPTION DRUG FORMULARY

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

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

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

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

Article 1. What Are the Basics of Your Coverage?

Blue Cross and Blue Shield of Louisiana (*Company*) issues this health Benefit Plan to the Group policyholder shown on the *Schedule of Benefits*.

As of the Benefit Plan Date shown on the Group's *Schedule of Benefits*, We agree to provide the Benefits specified in this Plan for Subscribers of the Group and their enrolled Dependents. A copy of this Plan serves as Your certificate of coverage. This Benefit Plan replaces any others previously issued to the Group Policyholder, as of 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. We encourage You to read it carefully.

Call Us if You have questions about Your coverage, or any limits to the coverage. Many sections of this Plan relate to other sections. You may not have all the information You need if You read just one section. Be aware that Your Physician does not have a copy of Your Plan, and does not know and cannot tell You Your Benefits.

Except for necessary technical terms, We use common words to describe the Benefits provided under this Plan. *We*, *Us* and *Our* mean Blue Cross and Blue Shield of Louisiana. *You*, *Your*, and *Yourself* mean the Subscriber and enrolled Dependent. Capitalized words are defined terms in Article 2: *What Terms Do We Use in this Plan?* A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

You must read and understand Your Plan Yourself. Your doctor does not have a copy of it, and does not know and cannot tell You what Benefits You have.

Facts About this Preferred Provider Organization (PPO) Plan

This Plan describes Your Preferred Provider Organization (PPO) coverage. You have an extensive Provider network available to You – Our Preferred Care PPO Network (Network). You can also get care from Providers who are not in this Network, but We will pay Benefits at a lower level.

If You go to Providers in Your Network, You will pay the least for care and get the most value from this Plan.

Most Benefits are subject to Your payment of a Deductible Amount. After You pay Deductible Amounts, Benefits are subject to two Coinsurance levels (for example, 80/20 or 60/40).

If the *Schedule of Benefits* shows that You must pay a Copayment, that means You must pay the Copayment amount to the Network Provider each time You receive Covered Services. Your choice of a Provider determines what Coinsurance level applies to the service.

If you receive Medically Necessary services, We will pay the highest Coinsurance level when You go to a Provider in the Preferred Care PPO Network. We will pay the lower Coinsurance level when You go to a Provider who is not in the Preferred Care PPO Network.

For Deductible Amounts and Coinsurance, see the *Schedule of Benefits*.

Our Provider Network

You choose which Providers will give You care. This choice will determine how much We pay and how much You pay for Covered Services.

Our Preferred Care PPO Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with Us to participate in Our PPO Provider Network and give services to Our Members. We call these Providers *PPO Providers*, *Preferred Providers*, or *Network Providers*. Oral Surgery Benefits are also available when given by Providers in the United Concordia Dental Network (Advantage Plus) or in Our dental network.

To receive the highest level of Benefits, always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Care Provider before You receive the service. To review a current paper Provider directory, go to **www.bcbsla.com** or call Customer Service at the number on Your ID card.

A Provider's status may change from time to time. Always verify the Provider's Network status before receiving services. A Provider may have a contract with Us to provide services at one location, but not at another location. Check Your Provider directory to verify that the services are In-Network at the location where You seek care.

Also, Providers in Your network may be contracted to perform certain Covered Services, but not others. When a Network Provider performs services that the Network Provider has not contracted with Us to perform (such as certain High-Tech Imaging Services or radiology procedures), Your Plan will pay for those services at the Non-Network Benefit level.

Always check Your Provider directory to verify that the Providers' services and locations are In-Network.

Receiving Care Outside the Preferred Care Network

The Preferred Care Network is an extensive network and should meet the needs of most Members. However, You choose which Providers will care for You and You may go to Providers who are not in Our Preferred Care Network.

We pay a lower level of Benefits when You go to Providers outside the Preferred Care Network. We may base Benefits on a lower Allowable Charge, and a penalty may apply. If You go outside Our Network, You pay more out of pocket and You pay a higher Copayment, Deductible Amount, and Coinsurance than if You had stayed in the Network. **These additional costs may be significant.** Also, We only pay part of those charges; You must pay the rest. To the extent required by applicable law, Your cost sharing for Emergency Medical Services will be at the Network level even if the Hospital is not in Your Network.

Ask Non-Network Providers to explain their billed charges to You BEFORE You receive care outside the Network. Review the *Sample Illustration of Your Costs When You Go to a Non-Participating Hospital*.

Receiving Emergency and Non-Emergency Care Outside Louisiana and Around the World

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

In the United States:

Members receive Network Benefits when Emergency and Non-Emergency Covered Services are provided by PPO Providers in other states.

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

Outside the United States:

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

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

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

3. Use a designated PPO Provider or Blue Cross Blue Shield Global® Core Provider to receive the highest level of Benefits.

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

5. The Member must obtain any required Authorizations from Blue Cross and Blue Shield of Louisiana.

Selecting and Using a Primary Care Physician for Plans with a Physician Office Visit Copayment

This Plan is sold with or without an office visit Copayment. The *Schedule of Benefits* states whether a Copayment applies.

If the *Schedule of Benefits* shows that a Copayment for Physician's office visits applies to Your Plan, You can go to a Primary Care Physician (PCP) or to a Specialist Physician. PCPs are family practitioners, general practitioners, internists, geriatricians, or pediatricians. PCPs will coordinate healthcare needs from consultation to hospitalization, will direct You to an appropriate Provider when necessary, and will help with any required Authorizations.

Services given by Allied Health Professionals may also be subject to the PCP or the Specialist Copayment amount, as shown on the *Schedule of Benefits*. You do not need a PCP referral before going to a Specialist in the Preferred Care PPO Network.

When You go to a Primary Care Physician, You pay the lowest Physician Copayment. Each member of the family may use a different PCP.

We may reduce or waive the Physician Office Copayment when You go to a Provider who participates in the Quality Blue Primary Care (QBPC) Program. QBPC Providers include family practitioners, general practitioners, internists, geriatricians, nurse practitioners, and physician assistants.

If one Provider directs You to another Provider, You must make sure that the new Provider is in the Preferred Care PPO Network before receiving care. If the new Provider is not in the Preferred Care PPO Network, We will pay Benefits at the Non-Network Benefit level and the Allowable Charge that applies to that Provider.

Authorizations

We must Authorize some services and supplies before You receive them. Your *Schedule of Benefits* lists the services, supplies, and Prescription Drugs that require this advance Authorization.

Your Plan will not pay for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless We Authorize these services. The services must be given either by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or a transplant facility in Our Blue Cross and Blue Shield PPO Provider Network, unless We otherwise approve it in writing. To find an approved transplant facility, call Customer Service at the number on Your ID card.

How We Figure What We Pay for Covered Services

When You Go to Preferred (PPO) Providers

Preferred Providers are Providers who have signed contracts with Us or another Blue Cross and Blue Shield plan to participate in a PPO Network. These Providers have agreed to accept the billed charges or an amount negotiated — whichever is less — as payment in full for Covered Services. This amount is the Preferred Provider's Allowable Charge. If You go to a Preferred Provider, We use this Allowable Charge to figure how much We pay for Your Medically Necessary Covered Services and how much You must pay.

When You Go to Participating Providers

Participating Providers are Providers who have signed contracts with Us or another Blue Cross and Blue Shield plan for other than a Preferred Care or PPO Network. These Providers have agreed to accept the billed charges or the negotiated amount — whichever is less — as payment in full for Covered Services. This amount is the Participating Provider's Allowable Charge. When You go to a Participating Provider, We use this Allowable Charge to figure how much We pay for Medically Necessary Covered Services and how much You must pay.

The Member 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.

When You Go to Non-Participating Providers

Non-Participating Providers do not have a contract with Us or any other Blue Cross and Blue Shield plan to participate in any Blue Cross and Blue Shield Network. These Providers are not in Our Networks. We have no fee arrangements with them.

We established an Allowable Charge for Covered Services provided by Non-Participating Providers. The Allowable Charge will be one of following as determined by Us:

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

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

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

You may pay significant costs when You go to a Non-Participating Provider. This is because the amount that some providers charge for a Covered Service may be higher than the established Allowable Charge. Also, Preferred and Participating Providers waive the difference between their actual billed charge and their Allowable Charge, while Non-Participating Providers will not.

You have the right to file an Appeal with Us to consider a higher level of Benefits if You went to a Non-Participating Provider who was the only Provider available to deliver the Covered Service within a 75-mile radius of Your home. To file an Appeal, follow the Appeal procedures in this Plan.

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

Sample Illustration of Your Costs When You Go to a Non-Participating Hospital

Note: The following example is for illustration only; it may not reflect Your actual Copayments, Deductible, and Coinsurance amounts. See the *Schedule of Benefits* to figure Your Benefits.

Example: A Member has this PPO policy with a $500 Deductible Amount. The PPO Network Benefits are 80%/20% Coinsurance. The Non-Network Benefits are 60%/40% Coinsurance. Assume he goes to the Hospital, has already met his Deductible Amount, and has gotten the necessary Authorizations before receiving a non-Emergency service. The Provider's billed charge for the Covered Services is $12,000.

For this service, We negotiated an Allowable Charge of $2,500 with PPO Hospitals. The Allowable Charge of Participating Providers is $3,000. Because we have no negotiated rate with the Non-Participating Hospital, he must pay the part of the bill that We do not pay, up to the Non-Participating Provider's billed charge.

Here's how much the Member would pay if they went to 3 different Hospitals for the same service.

The Member receives Covered Services from:	**Preferred Provider Hospital**	**Participating Provider Hospital**	**Non-Participating Provider Hospital**
	Network	**Non-Network**	**Non-Network**
Hospital Bill:	$12,000	$12,000	$12,000
Allowable Charge:	$2,500	$3,000	$2,500
We pay:	**$2,000** $2,500 Allowable Charge x 80% Coinsurance = $2,000	**$1,800** $3,000 Allowable Charge x 60% Coinsurance = $1,800	**$1,500** $2,500 Allowable Charge x 60% Coinsurance = $1,500
The Member pays:	**$500** 20% Coinsurance x $2,500 Allowable Charge = $500	**$1,200** 40% Coinsurance x $3,000 Allowable Charge = $1,200	**$1,000** 40% Coinsurance x $2,500 Allowable Charge = $1,000
Does Member receive a bill from the Hospital?	NO	NO	YES for $9,500
TOTAL AMOUNT MEMBER PAYS:	**$500**	**$1,200**	**$10,500**

When You Buy Covered Prescription Drugs

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

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

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

Mental Health and Substance Use Disorder Benefits

We have contracted with an outside company to perform certain administrative services related to Mental Health and substance use disorder services for Our Members. For help with these Benefits, see Your *Schedule of Benefits* or call Customer Service at the telephone number on Your ID card.

Member Incentives and Value-Added Services

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

Health Management and Wellness Tools And Resources

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

Customer Service Email Address

We have consolidated Our customer service emails into a single, easy-to-remember address: **help@bcbsla.com**. If You need to contact Us, You will find all options online, including phone, fax, email, postal mail and walk-in customer service. Go to www.bcbsla.com and click on *Need Help?* to access our Help Center which includes Our customer service contact information.

Identity Protection Services

We are committed to protecting Your identity. This includes protecting the safety and security of Your information. To support Our efforts, We offer optional Identity Protection Services. If You choose Identity Protection Services, they will include the following:

Credit monitoring which monitors activity that may affect credit.

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

Fraud resolution support that helps You address issues that arise about credit monitoring and fraud detection.

You can enroll in this service if Your Employer Group elected to participate.

You are no longer eligible for these services if Your coverage ends during the Plan year. In that case, Identity Protection Services will terminate at the end of the Plan year.

For information about Identity Protection Services, go to **www.bcbsla.com** or call Customer Service at the number on Your ID card.

Article 2. What Terms Do We Use in this Plan?

Accidental Injury – A condition that directly results from a traumatic bodily injury sustained only through accidental means from an external force. Injuries caused by chewing are not accidental injuries to teeth. If Benefits are available to treat a particular injury, Your Plan will cover an injury that results from an act of domestic violence or a medical condition.

Admission – The period for Inpatient Care from entry (*Admission*) into a Hospital or Skilled Nursing Facility or Unit for Inpatient care, until discharge. We count the date of entry and the date of discharge as 1 day.

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

- Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or investigational;
- Your eligibility to participate in the Benefit Plan;
- Any prospective or retrospective review determination; or
- A Rescission of Coverage.

Allied Health Facility – An institution— other than a Hospital — that the appropriate state agency licenses, where required, or that We approve to give Covered Services.

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

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

Allowable Charge –

- 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.
- For Non-Participating 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 We may agree to provide when it is beneficial both to the Member and to Us.

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

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

Ambulatory Surgical Center – An Allied Health Facility Provider that is established with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight, and which offers the following services whenever a patient is in the center:

- Anesthesia services as needed for medical operations and procedures performed;
- Provisions for patients' physical and emotional well-being;
- Provision for Emergency services;
- Organized administrative structure; and
- Administrative, statistical and medical records.

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

Applied Behavior Analysis (ABA) - Designing, implementing, and evaluating environmental modifications by using behavior stimuli and consequences to significantly improve social behavior. This analysis includes directly observing, measuring, and functionally analyzing how the environment affects behavior. The Louisiana Behavior Analyst Board certifies Providers of ABA as assistant behavior analysts or licenses them as behavior analysts.

Authorization (*Authorized*) – Based on the information provided, Our decision that an Admission, continued Hospital stay, or other healthcare service is Medically Necessary, in an appropriate healthcare setting, or at a necessary level of care and effectiveness. An Authorization does not guarantee payment. Also, an Authorization is not a determination about the Member's choice of Provider.

Autism Spectrum Disorders (ASD) – Any pervasive development disorder that the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association, Washington, D.C. (DSM) defines. 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, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified.

Bed, Board and General Nursing Service – Room accommodations, meals, and all general services and activities that Hospital employees provides to care for patients. This service includes all nursing care and nursing instructional services provided as part of the Hospital's bed and board charge.

Beneficiary – Someone a Member designates or by the terms of this Benefit plan designates, who is or may become entitled to a Benefit.

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

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

Benefit Plan – This agreement, including the *Application for Group Coverage*, the *Schedule of Benefits* and amendments or endorsements to this agreement, if any, that entitle the Subscriber and Dependents to specified health and Accidental Injury coverage. We also call the Benefit Plan Your *Plan*.

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

Bone Mass Measurement – A radiologic or radioisotopic procedure or other scientifically proven technologies performed on someone to identify bone mass or detect bone loss.

Brand-Name Drug – A patented Prescription Drug that the original drug manufacturer markets after the Food and Drug Administration (FDA) approves it, or that We identify as a Brand-Name product. We classify drugs as Brand-Name Drugs based on a nationally recognized pricing source. We may not classify the same drugs as *Brand-Name Drugs* that manufacturers or pharmacies do.

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

Care Coordination – Organized, information-driven patient care activities that are intended to facilitate the appropriate responses to Members' healthcare needs.

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

Case Management – A method of delivering patient care that emphasizes quality patient outcomes with efficient and cost-effective care. The process systematically identifies high-risk patients and assesses opportunities to coordinate and manage their total care to ensure the best health outcomes. Medical professionals provide these services and they focus on unusually complex, difficult, or catastrophic illnesses. We choose when to offer Case Management services to Members. Working with Your Physicians and with Your consent or the consent of Your family or caregiver, Our Case Management staff will manage care to most efficiently and effectively use 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 – Diagnosing conditions associated with the functional integrity of the spine and treating those conditions by adjusting, manipulating, and using 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 to correct interference with normal nerve transmission and expression.

Claim – Written or electronic proof — in a form We accept — of charges for Covered Services that You receive when You are insured under this Plan. The provisions that are in effect when You receive the service or treatment will govern how We process any Claim.

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 – A share of the costs for services that this Plan covers. This amount is calculated as a percentage — a percentage that We pay, and a percentage that You pay. (For example, We pay 80% for a service and You pay 20%.) After You pay any Deductible Amount, We apply Your percentage to the Allowable Charges to figure how much You pay. We apply Our percentage to the Allowable Charges to figure Your Benefits.

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

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 that a Physician who is not the attending Physician gives:

- for a condition that is not related to the primary diagnosis, or
- because the patient's condition is medically complex and requires more 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 about Your evaluation or treatment, which is given after the attending Physician asks for it. Consultations do not include the following:

- Those that Hospital rules and regulations require,
- Anesthesia consultations,
- Routine consultations for clearance for Surgery, or
- Those between colleagues who share medical opinions as a matter of courtesy and normally without charge.

Controlled Dangerous Substances – A drug, 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 You must pay when You receive Covered Services, as shown on the *Schedule of Benefits*. Your Network Provider may collect the Copayment directly from You.

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

Covered Service –Services or supplies specified in this Benefit Plan for which You may receive Benefits if a Provider gives them.

Creditable Coverage for HIPAA Portability - Coverage You had before under any individual or Group health plan including Medicare, Medicaid, government plans, church plans, COBRA, and military plans or State Children's Health Insurance Program (for example, LaCHIP). *Creditable coverage* does not include the following:

- Specific disease policies (such as cancer policies),
- Supplemental coverage (such as Medicare Supplement),
- Limited Benefits (such as accident only, disability insurance, liability insurance, Workers' Compensation, automobile medical payment insurance, credit only insurance, or
- Coverage for onsite 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 given safely and reasonably by someone who is not medically skilled, or that are designed mainly to help patients with daily living activities. These activities include:

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

We decide which services are *Custodial Care*.

Day Rehabilitation Program – A program that provides more than 1 hour of Rehabilitative Care after someone is discharged from an Inpatient Admission.

Deductible Amount -

- **Individual Deductible Amount**–
  - How much You must pay in a Benefit Period for Covered Services before We pay Benefits. See the *Schedule of Benefits* for the specific dollar amount. Certain Covered Services may have separate Deductible Amounts. See the *Schedule of Benefits*.
  - Network and Non-Network Benefit categories each carry a separate Individual Deductible Amount as shown on the *Schedule of Benefits*.
- **Family Deductible Amount** – How much Your family must pay in a Benefit Period before We pay Benefits. After You pay the entire Family Deductible Amount in a Benefit Period, We will pay Benefits for all family, regardless of whether each person has met the Individual Deductible Amount. See the *Schedule of Benefits* for the specific dollar amount for the Deductible.
- **Prescription Drug Deductible Amount** – How much You must pay in a Benefit Period before We pay a Prescription Drug Copayment or Coinsurance. See the *Schedule of Benefits* for the specific dollar amount. The Prescription Drug Deductible Amount is separate from 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. *Dentistry* is the practice in which someone:

- 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;

- Takes impressions of the human teeth or jaws or performs any phase of any operation incident to replacing a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or
- 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 Subscriber, whom We have been accepted for coverage as shown in the *Schedule of Eligibility*.

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures We recognize as accepted medical practice, which are given because of specific symptoms, and which are directed toward detecting or monitoring a definite condition, illness, or injury. A Provider must order Diagnostic Service before delivering it.

Durable Medical Equipment – Items and supplies used to serve a specific therapeutic purpose in treating an illness or injury. They can withstand repeated use; are generally not useful to someone who is not ill, injured, or diseased; and are appropriate to use in the patient's home.

Effective Date – The date Your coverage begins under this Benefit Plan. Benefits will begin at 12:01 AM on this date. See the *Schedule of Eligibility*.

Elective Admission – Any 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 We will pay Benefits under this Plan. If You enroll as a Special Enrollee, any period before that Special Enrollment is not an Eligibility Waiting Period.

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

Emergency – See *Emergency Medical Condition*.

Emergency Admission – An Inpatient Admission to a Hospital that results 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 who acts reasonably and possesses an average knowledge of health and medicine, to believe that not receiving immediate medical attention could reasonably be expected to result in:

- Seriously jeopardizing someone's the health, or if a woman is pregnant, her health or her unborn child's health;
- Seriously impairing bodily function; or
- Causing serious dysfunction of any bodily organ or part.

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

A. When within the capability of a Hospital or independent freestanding emergency department, the following services and items:
    1. A medical screening examination, including ancillary services routinely available to the Emergency department to evaluate an Emergency Medical Condition.

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

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

1. Covered Services under the Plan;

2. Furnished after the Member is stabilized; and

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

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

Employee – A person that the Employer has designated as a full-time Employee or Full-Time Equivalent.

Employer – Anyone who acts directly as an Employer — or indirectly in the interest of an Employer — in relation to an employee benefit plan. Employers includes a group or association of Employers who act for an Employer in such capacity.

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

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

Expedited Appeal – A request that We immediately review an Adverse Benefit Determination. This type of appeal involves any of the following:

- A medical condition for which the time frame for completing a standard Appeal would seriously jeopardize Your life or health or jeopardize Your ability to regain maximum function.
- In the opinion of the treating Physician, You may experience pain that cannot be adequately controlled while waiting for a standard medical Appeal decision.
- Our decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for Members who are currently in the emergency room, under observation, or receiving Inpatient care.

Expedited External Appeal – A request to have an Independent Review Organization (IRO) immediately review an initial Adverse Benefit Determination. This type of appeal involves any of the following:

- A medical condition for which the time frame for completing a standard External Appeal would seriously jeopardize Your life or health or jeopardize Your ability to regain maximum function, or a decision not to Authorize continued services if You are currently in the emergency room, under observation, or receiving Inpatient care.
- 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 Your health, including severe pain, potential loss of life, limb or major bodily function.

External Appeal – A request to have an Independent Review Organization (IRO) review Our initial Adverse Determination or to change a final Adverse Determination given on Appeal. You or Your authorized representatives may ask for an External Appeal involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission.

Full Time Equivalent (FTE) – An Employee who is:

- Employed on an average 30 or more hours a week; or
- Working fewer than 30 hours a week on average, but is in the stability period defined under Internal Revenue Code §54.4980H and regulations issued under it, and the Employer documents and verifies that the person is in the stability period.

A temporary Employee does not meet the eligibility requirements under this Plan, unless the 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 We identify as a Generic Drug. Based on a nationally recognized pricing source, We classify Prescription Drugs as a Generic Drugs. Manufacturers or pharmacies do not classify them for Us. We may not classify the same drugs Generic Drugs that manufacturers or pharmacies do.

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

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

Group – Any company, partnership, association, corporation or other legal entity that has applied for coverage in this Plan and has agreed to comply with all its terms and requirements. In this Benefit Plan, the Group is the Policyholder.

Habilitative Care – Healthcare services and devices that help a patient keep, learn or improve their skills and functioning for daily living. These services may include Physical Therapy, Occupational Therapy, Speech/Language Pathology, Cardiac Rehabilitation, Pulmonary Rehabilitation and other services for people with disabilities in a variety of inpatient and outpatient settings.

Home Health Care – Health given in someone's home by an organization that We approve and that the appropriate state agency licenses as a Home Health Care agency. These organizations primarily provide skilled nursing services by or under the supervision of a Registered Nurse (RN) licensed to practice in the state.

Hospice Care – An integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Members and their families during the final stages of terminal illness. A Physician directs an interdisciplinary team that centrally coordinates the full scope of health services. A Hospice Care agency that We approve provides the services and supplies.

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

Imaging Services -

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

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

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

Independent Review Organization (IRO) – An independent review organization that conducts external reviews of Our final Adverse Benefit Determinations. The IRO is not affiliated with Us and its decision is binding on both Members and Us.

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

Informal Reconsideration – A telephone request that We review a Utilization Management decision not to Authorize a service or treatment. You may ask for an Informal Reconsideration within 10 days after an initial or Concurrent Review determination.

Inpatient – A Member who is admitted to a Hospital as a registered bed patient for whom a Bed, Board, and General Nursing Service charge is made. An Inpatient's medical symptoms or condition must require a Physician or nurse to intervene continuously, 24 hours a day. If the services can be safely provided as an Outpatient, You do not meet the criteria for an Inpatient.

Intensive Outpatient Programs – Programs that have the capacity for planned, structured, service for at least 2 hours a day and 3 days a week, although some patients may need to attend less often. These encounters usually comprise coordinated and integrated multidisciplinary services. The range of services addresses mental or substance-related disorders and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services include multiple or extended treatment, rehabilitation, and counseling visits or professional supervision and support. Program models include structured *crisis intervention programs*, *psychiatric or psychosocial rehabilitation*, and some *day treatment*. (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here does not include times spent in these self-help programs, which community volunteers offer without charge).

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

- Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted when the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- 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:
    - Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation centers;
    - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    - Reference to federal regulations.

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

Medically Necessary (or *Medical Necessity*) - Healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies that Providers, exercising prudent clinical judgment, would provide to patients to prevent, evaluate, diagnose, or treat an illness, injury, disease or its symptoms, and that are:

- According to nationally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for patients' illness, injury or disease; and
- Not primarily for personal comfort or convenience of patients or Providers, and not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies or their sequence and that are as likely to produce equivalent therapeutic or diagnostic results for diagnosing or treating patients' illness, injury or disease.

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

Member – A Subscriber or a Dependent who is enrolled in this Benefit Plan. We may use common words in this Plan to describe the Benefits it provides. *You*, *Your*, and *Yourself* mean the Subscriber or enrolled Dependent.

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes:

- 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 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, that We determined.

The definition of *Mental Disorder* is the basis for determining Benefits, despite whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

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

Negotiated Arrangement (*Negotiated National Account Arrangement*) – An agreement negotiated between a Control/Home Licensee and 1 or more Par/Host Licensees for any National Account that is not delivered through the BlueCard® Program.

Network Benefits – Benefits for care from a Network Provider. We also call Network Benefits *In-Network*.

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

Network Provider – Providers who have signed an agreement with Us or another Blue Cross and Blue Shield Plan to participate as members of the Preferred Care Provider Network or another PPO Network. We also call these Providers *Preferred Providers* or *In-Network Providers*.

Newly Born Infant – Infants from birth until 1 month old or until they are well enough to be discharged to home from a Hospital or neonatal Special Care Unit, whichever period is longer.

Non-Network Benefits – Benefits for care You receive from Non-Network Providers. We also call Non-Network Benefits *Out-of-Network*.

Non-Network Provider – Providers who are not members of Our Preferred Care Provider Network or another Blue Cross and Blue Shield Plan PPO Network. Participating Providers and Non-Participating Providers are Non-Network Providers.

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 (OT) – Evaluating and treating physical injury or disease, cognitive impairments, congenital or developmental disabilities, or the aging process by using specific goal-directed activities, therapeutic exercises, or other interventions that alleviate impairment or improve functional performance. These can include:

- designing, fabricating, or applying Orthotic Devices;
- training in using Orthotic Devices and Prosthetic Devices;
- designing, developing, adapting or training in using assistive devices; and
- adapting environments to enhance functional performance.

Open Enrollment – Designated by the Group, a period of time each year during which a Subscriber and any eligible Dependents may enroll in this Benefit Plan.

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

Out-of-Pocket Amount – The highest amount of unreimbursable expenses (plus any Deductible Amount), that You must pay for Covered Services in 1 Benefit Period. For the specific dollar amount, see the *Schedule of Benefits.*

Outpatient – A Member 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 - Programs that provide structured and medically supervised day, evening, or night treatment for at least 4 hours a day and 3 days a week, although some patients may need to attend less often. The services are of essentially the same nature and intensity (including medical and nursing) as those provided in a hospital except that patients are in the program less than 24 hours a day. Patients are not considered residents at the program. The range of services addresses a Mental Health and substance-related disorder through an individualized treatment plan that a coordinated multidisciplinary treatment team provides.

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

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

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

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

Pre-Existing Condition – A physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specific period of time before the Enrollment Date or before the first day of coverage under another health 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 before delivery, delivery, post-delivery care, and any Complications arising from pregnancy.

Prescription Drugs – Medications — including Specialty Drugs — whose legal sale or dispensing requires an order from Physicians or other healthcare professionals. Medications must have the federally required product legend that stipulates that they may not be dispensed without a prescription and that they are currently approved by the FDA for safety and effectiveness, subject to *When Won't the Plan Pay? Limitations and Exclusions*.

Prescription Drug Coinsurance – The share of Allowable Charges for Prescription Drugs that this Plan covers. The amount is calculated as a percentage — a percentage that We pay and a percentage that You pay. (For example, We pay 80% and You pay 20%.) After You pay any Prescription Drug Deductible Amount, We apply Your percentage to the Allowable Charges for Prescription Drugs to figure how much You pay. We apply Our percentage to the Allowable Charges for Prescription Drugs to determine Your Benefit. A different Prescription Drug Coinsurance may be required for the different drug tiers you buy at a pharmacy or through the mail.

Prescription Drug Copayment – The amount a Member must pay for each prescription at a participating pharmacy when 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 this Plan covers.

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

Primary Care Physician (PCP) - A Physician who is a family practitioner, general practitioner, internist, geriatrician, or pediatrician. 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. The attending Physician must order these services. These services must also require the technical skills of an RN or LPN in shifts of at least 8 continuous hours.

Prosthetic Appliance or Device – Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part. Limb prostheses are artificial limbs that are designed to maximize patients' function, stability, and safety, that are not surgically implanted; and that 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 by replacing 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 that We approve, is licensed where required, and performs within the scope of that license. If a Provider does not have a state or federal license, We have the right to define all criteria under which a Provider's services may be offered to You for Benefits to apply to a Provider's Claims. If Providers who do not meet these criteria submit Claims, We will not pay them.

- **Preferred Provider** – A Provider who has signed a contract with Us or another Blue Cross and Blue Shield plan to participate in a PPO Network. We call these Providers *PPO Providers*, *Preferred Providers*, or *Network Providers*.
- **Participating Provider** – A Provider who has a signed contract with Us or another Blue Cross and Blue Shield plan for other than a Preferred Care or PPO Network.
- **Non-Participating Provider** – A Provider who has not signed a contract with Us or another Blue Cross and Blue Shield plan.

Provider Incentive – Additional compensation that a payer pays to a healthcare Provider, based on how the Provider complies with agreed-upon procedural and outcome measures for a particular group or population of Members.

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 a contract to participate in the Quality Blue Primary Care program.

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

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

Rescission – Cancellation or discontinuance of coverage that has retroactive effect. Rescission includes a cancellation that treats a policy as void from the time the Group enrolls or a cancellation that voids Benefits paid up to 1 year before the cancellation.

Residential Treatment Center – A 24-hour, non-acute care treatment setting to actively treat specific impairments of mental health or substance use disorders.

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

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

- For an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- For a chronic illness or condition, a condition that is:
  - life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical care over a prolonged period of time.

Skilled Nursing Facility or Unit – A facility licensed by the state in which it operates and is not a nursing home or a unit within a Hospital (unless We approved skilled nursing in the nursing home or unit within a Hospital). The facility provides:

- Inpatient medical care, treatment and skilled nursing care as defined by Medicare and that meets the Medicare requirements for this type of facility;
- Full-time supervision by at least one (1) Physician or Registered Nurse;
- 24-hour nursing service by Registered Nurses or Licensed Practical Nurses; and
- Utilization review plans for all patients.

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

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Benefit Plan) within 30 days after 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 as a Primary Care Physician.

Specialty Drugs – Specialty drugs are typically high in cost and 1 or more of the following characteristics:

- Required specialized patient training on administering the drug (including supplies and devices needed for administration);
- Required coordination of care before drug therapy starts or during therapy;
- Unique patient compliance and safety monitoring requirements;
- Unique requirements for handling, shipping, and storing the drug; and
- Restricted access or limited distribution.

Specialty drugs also include biosimilars. Biosimilars are drugs that are similar to currently marketed brand name drugs, but do not have the same active ingredient. We do not consider biosimilars to be Generic Drugs.

Speech/Language Pathology Therapy – Treating speech, language, cognitive-communication, and swallowing impairment to improve or restore function.

Spouse – The Subscriber's legal Spouse.

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

Surgery –

- The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic exams, incisional and excisional biopsies and other invasive procedures.
- The correction of fractures and dislocations.
- Pregnancy Care to include vaginal deliveries and caesarean sections.
- Usual and related pre-operative and post-operative care.
- Other procedures that We define and approve.

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

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

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

Temporomandibular/Craniomandibular Joint Disorder – Disorders resulting in pain 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 include: colds and flu, sprains, stomach aches, and nausea. You may receive Urgent Care from an Urgent Care Center that is in Our Network if You need non-Emergency medical care or Urgent Care after Your Physician's normal business hours.

Urgent Care Center – A clinic with extended office hours that provides Urgent Care. Urgent Care Centers do not provide routine follow-up care or wellness exams; for those they refer patients to their regular Physician. Patients do not need scheduled appointments at Urgent Care Centers.

Utilization Management – Evaluation of necessity, appropriateness, and efficiency of using 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 or any other policy of insurance. Group is never under any obligation to accept Value-Added Services, and Company may cease offering and paying for Value-Added Services at any time.

Value-Based Program (VBP) – An outcomes-based payment arrangement or a coordinated care model facilitated with 1 or more local Providers that is evaluated against cost and quality metrics and factors. A VBP is reflected in the Provider's payment.

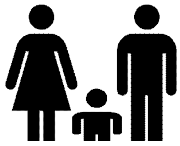
Value Drugs – Low-cost Generic Drugs and some low-cost Brand-Name Drugs.

Waiting Period – See Eligibility Waiting Period.

Well Baby Care – Routine examinations of an infant who is younger than 24 months old for whom no diagnosis is made.

Article 3. Schedule of Eligibility

By amendment, We may delete or revise any eligibility requirement in this Plan that is not mandated by state or federal law.



You cannot be enrolled in this Plan as both an Employee and a Dependent. Dependents can only be covered by one (1) Employee.

A. Eligibility

1. **Subscriber**. To be eligible to enroll as a Subscriber, You must be:

   a. an Employee who has satisfied any criteria We designate, has satisfied any Eligibility Waiting Period the Group requires, and who is working the number of hours We designated in the *Application for Group Coverage*.

   b. a retiree who satisfies any criteria We designated, and if shown as covered on this Group's *Schedule of Benefits*.

   c. an elected official who satisfies any criteria We designated, and if shown as covered on this Group's *Schedule of Benefits*.

Who May This Plan Cover?

A Subscriber	■ You, the Employee, retiree, or elected official
Your Dependents	■ Your Spouse ■ Your children who meet the criteria below

Subscribers and Dependents are both called *Members*.

2. **Dependent**. To be eligible to enroll as a Dependent, You must meet the following criteria when You enroll. To be eligible to keep coverage, You must continue to meet the criteria. If You do not continually meet the criteria, We may decide that You are no longer eligible for coverage and Dependent Benefits may end as We describe in this Plan.

   a. **Spouse**

   b. **Children**: A child under age 26 who is one of the following:

      (1) born of the Subscriber; or

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

      (3) legally adopted by the Subscriber; or

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

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

      (6) a stepchild of the Subscriber; or

(7) a grandchild living with the Subscriber if the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or

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

B. Application for Coverage

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

2. Before this Plan will cover You, the Group will submit all enrollment information to Us.

3. This Plan will not cover You unless We have accepted the enrollment form or enrollment information in a format We accept and have issued an ID card or other written notice of acceptance. Even if premiums are paid, coverage will not begin unless We have issued an ID card or other written acceptance. Without an ID card or written acceptance, Our liability is limited to refund of premiums paid.

4. We will not issue or renew this Plan unless the percentage of Eligible Persons specified in the *Application for Group Coverage* is enrolled.

C. Available Classes of Coverage

The following classes of coverage are available subject to the classes of coverage that the Group selects on the *Application for Group Coverage*. The Group has the right to change the classes of coverage by sending a request to change classes to Our Underwriting Department.

1. **Subscriber Only** —for the Subscriber only.

2. **Subscriber and Spouse** —for the Subscriber and Spouse.

3. **Subscriber and Family** —for the Subscriber, Spouse, and 1 or more Dependent children.

4. **Subscriber and Children** —for the Subscriber and one (1) or more Dependent children.

5. **Subscriber and Dependent** —for the Subscriber and one (1) Dependent.

Which Classes of Coverage Are Possible with this Plan?	
Subscriber Only	For You only
Subscriber and Spouse	For You + Your spouse
Subscriber and Family	For You, Your spouse, + 1 or more children
Subscriber and Children	For You + 1 or more children
Subscriber and Dependent	For You + 1 Dependent

D. Effective Date of Coverage

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

1. If You are an Eligible Person on this Group's Benefit Plan Date and You enroll for coverage for Yourself or for Yourself and any eligible Dependents on or before that date, this Group's Benefit Plan Date will be the Effective Date of coverage.

2. If You become an Eligible Person after this Group's Benefit Plan Date and You enroll for coverage for Yourself or for Yourself and any eligible Dependents on or before the eligibility date and We receive the enrollment form within 30 days of the eligibility date, the Effective Date of coverage will be the eligibility date.

3. If You are an Eligible Person and We do not receive Your *Application for Group Coverage* for Yourself or for Yourself and any eligible Dependents within 30 days of the eligibility date or Special Enrollment Period as described below, We will not enroll You in this Plan. You will be eligible to enroll for coverage during the next Open Enrollment Period.

4. If You are a Subscriber and Your child is born (and You have *Subscriber and Family* or *Subscriber and Children* coverage), and We receive the enrollment form within 30 days of the date of birth, the Effective Date of coverage will be the date of birth.

E. Court-ordered Determination

If a court orders that an eligible Dependent must be covered under an Employee's Benefit Plan, if the Employee is not already enrolled, the Employee must enroll himself and the Dependent by completing an enrollment form and sending it to Our home office within 30 days after the court order. If the Dependent is enrolled on time, coverage will be effective on the date of the court order.

F. Special Enrollment

1. Special Enrollment Due to Loss of Certain Other Coverage

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

   If You lose other coverage because You did not pay premiums or required contributions on time or lose other coverage for cause (such as because You filed fraudulent Claims or intentionally misrepresented a material fact for the plan), You are not a Special Enrollee and You have no special enrollment rights.

   If You are an Eligible Person who is not enrolled in this Plan, You may be allowed to enroll as a Special Enrollee if each of the following conditions is met:

   a. You must be eligible for coverage under the terms of this Plan; and

   b. You must have declined enrollment under this Plan when offered;

   c. You 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 finished;

         (b) the Employer or other responsible entity did not pay required premiums on time;

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

(d) the person incurs a Claim that would meet or be more than a lifetime limit on all Benefits and no other COBRA continuation coverage is available to the person; or

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

(a) loss of eligibility for coverage. *Loss of eligibility* for coverage includes the following:

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

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 person no longer lives or works in the HMO service area, whether or the person chooses or not, and no other health coverage is available to the person; or

iv. a plan no longer offers any Benefits to the class of similarly situated people.

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

A Special Enrollee under this section must request enrollment for coverage under this Benefit Plan within 30 days after other coverage ends (or after the Employer stops contributing toward the other non-COBRA coverage). If We receive this enrollment within 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 30 days of the loss of other coverage, but is received within 60 days of loss of other coverage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if We do not receive the request for enrollment form within 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 Plan provides a Special Enrollment Period for an Employee or family Dependents if either:

(1) are covered under Medicaid or State Children's Health Insurance Program (CHIP), and lose that coverage because of loss of eligibility; or

(2) they become eligible for premium assistance under the CHIP program.

To qualify, You must request coverage in this Plan no later than 60 days after either the date of coverage termination under Medicaid or CHIP or the date Employee or Dependent is determined to be eligible for such premium assistance. We must receive Your request for special enrollment under this section within the 60-day period after loss of coverage or the date Employee or Dependent is determined to be eligible. When special enrollment under this section is made on time and We receive it on time, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP or the date Employee or Dependent is eligible for premium assistance.

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

3. Special Enrollment Due to Acquiring a Dependent

   a. During a special enrollment period, Dependents of a participating Employee, retiree, or elected official may be enrolled on the plan. If You are not already participating and are a current Employee or elected official, You may enroll with the Dependents if You have served any Eligibility Waiting Period but have not enrolled during a previous enrollment period. (If You are a retiree and You are not currently participating, You do not have these rights for adding Dependents and may not enroll in the plan.)

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

   c. If the Group offers multiple health plan options, You may choose another option for Yourself and Dependents when special enrollee status applies.

   d. Newly Born infants (either natural born or adopted) are automatically covered during a 30-day period, as described below. Any period of automatic coverage runs at the same time as the Special Enrollment Period for adding newborns to this Plan.

   e. The Special Enrollment Period described in this subparagraph is at least 30 days and begins either on the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption, whichever is later. If You do not request enrollment in time, We will deny Your request and any period of automatic coverage for newborns will end.

   f. In the case of a birth, adoption, or placement for adoption, if You are a current Employee, You may enroll Yourself, Your Spouse, and the newborn or adopted child and other eligible dependent children. You must request the enrollment by signing an enrollment form no later than 30 days after the birth, adoption, or placement for adoption. If We receive the enrollment form within 30 days of the event, coverage will become effective on the date of birth for a natural Newly Born Infant, and on the date of adoption or placement for adoption for an adopted Newly Born Infant. A Subscriber may enroll an unborn child before birth, however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth.

      If We do not receive the signed enrollment form within 30 days of birth, adoption or placement for adoption, any automatic coverage period will end. If We do not receive the signed enrollment form within 30 days of the event but receive it within 60 days of the event, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. No coverage will be available if You do not sign the enrollment form within 30 days of the birth, adoption, or placement of adoption. Coverage will not be available if We do not receive the enrollment form within 60 days of birth, adoption, or placement for adoption.

   g. If You are a current Employee and You get married, You may enroll Yourself and new Dependents You gain because of the marriage. You must request the enrollment by signing an enrollment form within 30 days of the marriage. Coverage will become effective on the date of marriage if We receive the enrollment form within 30 days of the marriage. If We do not receive the enrollment form within 30 days of marriage, but receive it within 60 days of marriage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment.

      Coverage will not be available if You do not sign the enrollment form within 30 days of the marriage. Coverage will not be available if We do not receive the enrollment form within 60 days of marriage.

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

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

      (1) Your child will be covered automatically for 30 days from birth or until the child is well enough to be discharged to home from the Hospital or neonatal Special Care Unit, whichever is longer. This is the *automatic coverage period*. Automatic coverage for the child will be provided on the mother's policy, if any. If the mother has no policy, then automatic coverage will be provided on the father's policy if he has notified Us of the birth of the child. Coverage for the child will continue in effect after that, only if We receive a completed *Employee Enrollment / Change Form* before the automatic coverage ends, if any required premiums are paid when billed.

      (2) If We do not receive the completed *Employee Enrollment / Change Form* within this period, coverage for the child will end when the automatic coverage period ends. Any later request to add the child to the Plan must be made at open enrollment or under a special enrollment provision.

   b. If a child is born to a Subscriber who has coverage for Dependent children (either *Subscriber and Family* coverage or *Subscriber and Children* coverage), the Effective Date for that child's coverage will be the date of birth. You must notify Us within 180 days of the birth to update Our records.

5. Automatic Coverage Period for Newly Born Adopted Infants

   a. If You have *Subscriber Only* coverage or *Subscriber and Spouse* coverage:

      If within 30 days of the birth of a child, the child is either: legally placed into Your home for adoption after a voluntary act of surrender to the custody of You or Your legal representative which becomes irrevocable, or is subject to a court order awarding custody to You, the following will apply:

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

      (2) If We do not receive the completed *Employee Enrollment / Change Form* within the automatic coverage period, coverage for the infant will end when the automatic coverage period ends. You may add the child to Your Plan later at open enrollment or under a special enrollment provision.

   b. For You have *Subscriber and Family* coverage or *Subscriber and Children* coverage:

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

6. For Dependents to be enrolled in this Plan, in all special enrollee circumstances, an Employee, retiree or elected official must be enrolled.

Article 4. Your Benefits

By amendment, We may delete or revise any eligibility requirement in this Plan that is not mandated by state or federal law.

A. Benefit Categories

1. **Network Benefits** (*In-Network*) – Benefits for medical care when You go to a Preferred Care Provider. When You go to a Network Provider, You will receive the highest level of Benefits on this Plan.

2. **Non-Network Benefits** (*Out-of-Network*) – Benefits for medical care when You go to a Provider who is not contracted with Us as a Preferred Care Provider. Participating Providers and Non-Participating Providers did not sign a contract with Our Preferred Care PPO Network. When You go to a Non-Network Provider, You will receive a lower level of Benefits on this Plan.

B. Deductible Amounts

1. Subject to the Deductible Amounts shown on the *Schedule of Benefits*, the maximum limitations hereinafter provided, and other terms and provisions of this Plan, Your Plan pays according to the Coinsurance shown on the *Schedule of Benefits* toward Allowable Charges incurred for Covered Services by a Member during a Benefit Period. The following Deductible Amounts may apply to Benefits in this Plan.

   a. **Benefit Period Deductible Amount:** As shown on the *Schedule of Benefits*, the dollar amount of charges for Covered Services that You must pay within a Benefit Period before We start paying Benefits. If shown on the *Schedule of Benefits,* a separate Deductible Amount may apply to certain Covered Services.

   b. **Family Deductible Amount:** As shown on the *Schedule of Benefits,* if You are in a class of coverage with more than 1 Member, this aggregate amount is the highest Deductible Amount that Your family must pay before We start paying Benefits. Once Your family has paid its Family Deductible Amount, this Plan starts paying Benefits for all family Members, even if each has not met the individual Benefit Period Deductible Amount. No family Member may pay more than the Benefit Period Deductible Amount to satisfy Your family's total amount. Only Benefit Period Deductible Amounts accrue to the Family Deductible Amount.

   c. **Prescription Drug Deductible Amount:** The dollar amount, if shown on the *Schedule of Benefits*, which each Member must pay within a Benefit Period before paying a Prescription Drug Copayment. A Prescription Drug Deductible Amount is in addition to other Deductible Amounts. It does not accrue to the Benefit Period Deductible Amount or the Family Deductible Amount.

2. Each Deductible on the *Schedule of Benefits* may have separate in-network and out-of-network amounts.

3. We will apply Your Claims to the Deductible Amount in the order in which We receive and process Claims. It is possible that one Provider may collect the Deductible Amount from You, then when You go to another Provider for Covered Services, that Provider also collects Your Deductible Amount. This generally occurs when We have not received and processed Your Claims. Our system will only show the Deductible Amount applied for Claims We have processed. Therefore, You may need to pay toward the Deductible Amount until

Your Claims are submitted and processed, showing that You have met the Deductible Amount. If You pay more than Your Deductible Amount, You are entitled to receive a refund from the Provider You overpaid.

4. If We pay a Provider amounts that You should have paid, such as Copayments, Deductibles or Coinsurance, We may collect those amounts directly from You. You agree that We have the right to collect those payments from You.

C. Coinsurance Amount

If the *Schedule of Benefits* shows a Coinsurance for a Covered Service, You must first pay any Deductible Amount before We apply the Coinsurance. After You have paid any Deductible Amount, and subject to the maximum limitations and other terms and provisions of this Plan, We will pay Benefits in the Coinsurance toward Allowable Charges for Covered Services. Our actual payment to a Provider or payment to You satisfies Our obligation to pay Benefits under this Plan.

D. Copayment Services

If a Copayment is shown on the Schedule of Benefits, the Member must pay a Copayment each time applicable Covered Services are rendered, until the Member meets his Out-of-Pocket Amount. 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 performed in the Physician office that are subject to Copayments are:

    a. office visits and consultations;

    b. Surgical procedures;

    c. injections, allergy serums, and vials of allergy medications;

    d. Dialysis;

    e. Chemotherapy; and

    f. infusion therapy; and

    g. Diabetes education.

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

    a. Radiation treatment;

    b. Low-Tech Imaging Services; and

    c. Lab tests.

3. Copayments do not apply to every service and/or supply rendered in an office setting. Examples of services rendered in an office setting that are subject to a Deductible Amount and applicable Coinsurance are listed below:

a. allergy testing;

b. Physical Therapy, Occupational Therapy, and Speech Therapy;

c. Prescription Drugs administered in the Provider's office;

d. medical and surgical supplies; and/or

e. High-Tech Imaging Services.

E. Out-of-Pocket Amount

1. After You have met the Out-of-Pocket Amount shown on the *Schedule of Benefits*, We will pay 100% of the Allowable Charges for Covered Services for the rest of the Benefit Period.

2. The following accrue to the Out-of-Pocket Amount of this Plan:

   a. Deductible Amounts;

   b. Coinsurances; and

   c. Copayments.

3. The following do not accrue to the Out-of-Pocket Amount of this Plan:

   a. any charges that are more than the Allowable Charge;

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

   c. charges for non-covered services.

4. 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.

F. Accumulator Transfers

Members' needs sometimes require that they transfer from one policy to another. Types of transfers include moving from one Employer's plan to another, from a Group policy to an individual policy, from an individual policy to a Group policy, or from Our policy to an HMO Louisiana, Inc. policy. The type of transfer determines whether Your accumulators are carried from the old policy to the new policy. Accumulators include Deductibles, Out-of-Pocket Amounts, and Benefit Period Maximums.

Article 5. Benefits for When You Go into a Hospital

We must Authorize All Admissions (including elective or non-emergency, Emergency, Pregnancy Care, Mental Health and substance use disorder Admissions) as shown in Article 16: *Care Management* and the *Schedule of Benefits*.

Also, at regular intervals during the Inpatient stay, We will perform a Concurrent Review to determine whether continued hospitalization and the level of care are appropriate. You must pay any Deductible Amount, Copayment, and any Coinsurance shown on the *Schedule of Benefits*.

If You receive services from a Physician in a Hospital-based clinic, the Physician, the clinic, and the facility may charge You.

This Plan covers the following services when You go to a Hospital:

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Member who needs 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 We approve.
4. In a Residential Treatment Center for Members with Mental Health and substance use disorder Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

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

C. Pre-Admission Testing

Your Plan pays for the Outpatient Facility charge and associated professional fees for Diagnostic Services given within 72 hours of a scheduled procedure performed at an Inpatient or Outpatient Facility.

Article 6. Your Medical and Surgical Benefits

Your Plan pays for the following surgical and medical services, but they may require Our Authorization. See the *Schedule of Benefits* to see which services require Authorization. You must pay any Deductible Amounts, Copayments and Coinsurance shown on the *Schedule of Benefits*.

A. Surgical Services

1. Surgery

   a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. We define the pre-operative and post-operative period. It 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 other 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, We will pay Benefits as follows:

   a. Primary Service

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

      (2) We will base Benefits for the primary service on the Allowable Charge.

   b. Secondary Service

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

   c. Incidental Service

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

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

   d. Unbundled Services

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

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

e. Mutually Exclusive Services

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

3. Assistant Surgeon

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

4. Anesthesia

a. The Plan covers general anesthesia services 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. Your Plan also covers other forms of anesthesia services that We define and approve. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.

b. Unless We decide otherwise, Your Plan will cover anesthetic or sedation procedures performed by the operating Physician, assistant surgeon, or an advanced practice registered nurse as a part of the surgical or diagnostic procedure.

c. To figure Benefits for anesthesia, We will apply the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Your Plan pays for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, We may divide the payment between the medical direction or supervision and administration of anesthesia, when they are billed separately.

5. Second Surgical Opinion

Your Plan covers consultation and directly related Diagnostic Services to confirm the need for elective Surgery. Second or third opinion consultant must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory to receive Benefits.

B. Inpatient Medical Services

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

1. Inpatient medical care visits.

2. Concurrent Care.

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

C. Outpatient Medical Services and Surgical Services

1. Home, office, and other Outpatient visits to examine, diagnose, and treat 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 Plan).

3. Diagnostic Services.

4. Services of an Ambulatory Surgical Center.

5. Services of an Urgent Care Center.

Article 7. Your Benefits for Prescription Drug

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

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

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

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

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

D. Prescription Drug Formulary

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

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

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

1. **Open Prescription Drug Formulary**

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

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

a. **Open Formulary – (Four Tier)**

(1) The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Member may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Member may be required to pay a different Copayment or Coinsurance depending on whether the Member'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 Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. You may call Customer Service or go to **www.bcbsla.com/pharmacy** to identify the tier classification of Your Prescription Drug.

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

(b) **Tier 2 -** Preferred Brand Drugs: Brand-Name Drugs

(c) **Tier 3 -** Non-Preferred Brand/Generic Drugs: 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.

(d) **Tier 4 -** Specialty Drugs: High-cost Brand-Name Drugs that are identified as Specialty Drugs.

b. **Open Formulary – (Two Tier)**

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

(a) **Tier 1** – Generic Drugs

(b) **Tier 2** – Brand-Name Drugs

c. **Open Formulary – (Five Tier)**

(1) The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Member may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Member may be required to pay a different Copayment or Coinsurance depending on whether the Member'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 Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. You may call Customer Service or go to **www.bcbsla.com/pharmacy** to identify the tier classification of Your Prescription Drug.

(a) **Tier 1 –** Primarily Generic Drugs, although some Brand-Name Drugs may fall into this category.

(b) **Tier 2 –** Brand-Name Drugs.

(c) **Tier 3 –** Brand-Name Drugs or Generic Drugs that may have a therapeutic alternative as a Tier 1 or Tier 2 drug. Covered compounded drugs are included in this tier.

(d) **Tier 4 –** Multi-Source Brand Drugs.

(e) **Tier 5 –** Injectable drugs that are intended to be self-administered. Insulin may be included in another tier.

2. **Closed Prescription Drug Formulary**

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

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

a. **Closed Formulary – (Four Tier)**

(1) The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Member may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Member may be required to pay a different Copayment or Coinsurance depending on whether the Member'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 Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. You may call Customer Service or go to www.bcbsla.com/pharmacy to identify the tier classification of Your Prescription Drug.

(3) If a drug review request is approved, You 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.

(a) **Tier 1 –** Value Drugs: Primarily Generic Drugs, although some Brand-Name Drugs may fall into this category.

(b) **Tier 2 –** Brand-Name Drugs

(c) **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.

(d) **Tier 4 –** Specialty Drugs: High-cost Brand-Name Drugs that are identified as Specialty Drugs.

b. **Closed Formulary – (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 shown in the Schedule of Benefits. Generic Drugs and Brand-Name Drugs may be subject to different Coinsurance Amounts.

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

(a) **Tier 1** – Generic Drugs

(b) **Tier 2** – Brand-Name Drugs

c. **Closed Formulary – (Three Tier)**

(1) The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Member may be required to pay a different Copayment or Coinsurance depending on whether the Member'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 Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. You may call customer service or go to www.bcbsla.com/pharmacy to identify the tier classification of Your Prescription Drug.

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

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

(b) **Tier 2** – Includes traditional brands and generics, specialty brands and generics, and biosimilars

(c) **Tier 3** – Includes traditional brands and generics, specialty brands and generics, biosimilars, and covered compound drugs

E. Drug Utilization Management Program

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

1. **Prior Authorization** – As part of Our Drug Utilization Management program, Members and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on Our website at **www.bcbsla.com/pharmacy** or by calling the customer service telephone number on the Member's ID Card. If the Prescription Drug requires prior Authorization, the Member's Physician must call the medical Authorization telephone number on the Member'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 Member's prescription is filled, Our Pharmacy Benefit Manager or We perform quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g., refill prior to seventy-five percent (75%) day supply used).

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

4. **Step Therapy** – Certain drugs and/or drug classes are subject to Step Therapy. In some cases, We may require the Member to first try one or more Prescription Drugs to treat a medical condition before We will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, We may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then We will cover a prescription written for Drug B. However, if Your Physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the drug.

5. **Step Therapy Overrides** – Your 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. Select diabetic supplies, including, but not limited to, necessary continuous glucose monitors and associated supplies, Insulin Syringes, and Test Strips Are Covered Under the Prescription Drug Benefit.

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

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

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

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

Article 8. Your Benefits for Preventive or Wellness Care

The following Preventive or Wellness Care services are available to a Member. If a Member receives Covered Services for Preventive or Wellness from a Network Provider, Benefits will be paid at 100% of the Allowable Charge, unless otherwise stated below. If a Member receives Covered Services for Preventive or Wellness Care from a Non-Network Provider, Benefits will be subject to Copayment amounts (if applicable) and Coinsurance shown in the Schedule of Benefits. The Deductible Amount will not apply to Covered Services received for Preventive or Wellness Care. Preventive or Wellness Care services may be subject to other limitations shown on the Schedule of Benefits.

A. Well Woman Examinations

1. Routine annual visits to an obstetrician or gynecologist. Additional visits that Your obstetrician or gynecologist recommends may be subject to the Deductible Amount, Copayment or Coinsurance shown on the *Schedule of Benefits,* unless they are preventive services.

2. One routine Pap smear per Benefit Period.

3. This Plan covers all film mammograms and 3-D mammograms (digital breast tomosynthesis), breast ultrasound at no cost to You when You go to a Network Provider. If You go to a Non-Network Provider, You will pay Coinsurance for mammograms as shown on the *Schedule of Benefits*.

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

B. Physical Examinations and Testing

1. **Routine Wellness Physical Exam** – Certain routine wellness diagnostic tests that Your Physician orders are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Care Benefit include 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. Your Plan covers these High-Tech Imaging Services under standard plan Benefits when the tests are Medically Necessary.

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

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

   A second visit is permitted if recommended by Your Physician for follow-up treatment within 60 days after either visit if related to a condition diagnosed or treated during the visits.

4. **Colorectal Cancer Screening** – Fecal immunochemical test for blood (FIT), Cologuard (FIT-fecal) DNA testing, Computed Tomographic (CT) colonography, flexible sigmoidoscopy, or routine colonoscopy provided according to 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 at no cost to You when You go to a Network Pharmacy. Routine colorectal cancer screening does not mean services otherwise excluded from Benefits because the services We deem to be Investigational. The Plan covers brand-name colonoscopy preparation and supplies at no cost to You only when Your Physician prescribes brand-name colonoscopy preparation and supplies because You cannot tolerate selected generic colonoscopy preparation and supplies.

5. **Bone Mass Measurement** – scientifically proven tests to diagnose and treat osteoporosis if You are:

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

   b. receiving long-term steroid therapy; or

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

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

C. Immunizations

The Benefit Period Deductible Amount does not apply to immunizations.

1. All state mandated immunizations including the complete basic immunization series as defined by the state health officer and required for school entry for children up to age 6.

2. Immunizations recommended by Your Physician.

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

Services recommended by the U.S. Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration are covered. For a copy of Our Preventive Care Services brochure, go to: **www.bcbsla.com/preventive**.

The list of covered services changes from time to time. For a current list of recommended Preventive or Wellness Care services required by PPACA, go to the U.S. Department of Health and Human Services' website at: **https://www.healthcare.gov/preventive-care-benefits/** or call Customer Service at the number on Your ID card.

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, these services may be covered, up to the Network allowable at no cost when required by applicable law. Non-Network Providers are able to balance bill Members up to their full-billed charge. Balance bills do not apply to the Out-of-Pocket Maximum. When not required by applicable law to be covered at no cost to a Member, these services are subject to plan Benefits, including applicable 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.

F. New Recommended Preventive or Wellness Care Services

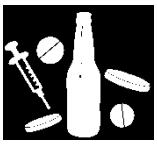
This Plan covers new services on the date required by law for that coverage.

Article 9. Your Mental Health Benefits

A. Your Plan pays for Mental Health treatment. A Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional must treat You. Coverage to treat Mental Health 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 is available at no cost to the Member when performed within seven (7) days of the discharge by a Network Provider approved by Us as a behavioral health Provider. Additional visits will be paid subject to plan Benefits.

Article 10. Your Substance Use Disorder Benefits

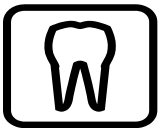


A. Your Plan pays for substance use disorders treatment. A Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional must treat You. Your Plan will only cover services to treat abuse of alcohol, drugs or other chemicals, and the physiological or psychological dependency that results from 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 Member when performed within seven (7) days of the discharge by a Network Provider approved by Us as a behavioral health Provider. Additional visits will be paid subject to plan Benefits.

Article 11. Your Benefits for Oral Surgery

You receive the highest level of Benefits when You go to Providers in the Preferred Care Network, the United Concordia Dental Network (Advantage Plus), or Our dental network.



For a copy of the directory, go to **www.bcbsla.com** or call Customer Service at the number on Your ID card.

A. This Policy Only Covers the Following Services or Procedures

1. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
2. Extraction of impacted teeth.
3. 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 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.)
4. Excision of exostoses or tori of the jaws and hard palate.
5. Incision and drainage of abscess and treatment of cellulitis.
6. Incision of accessory sinuses, salivary glands, and salivary ducts.
7. Anesthesia for the above services or procedures when an oral surgeon gives them.
8. Anesthesia for the above services or procedures when given by a dentist who holds all required permits or training to administer such anesthesia.
9. Anesthesia when given in a Hospital setting and for associated Hospital charges when Your mental or physical condition requires dental treatment in a Hospital setting.

10. 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.

B. Benefits for Head and Neck Cancer Patients

When specifically required to restore bodily function for head and neck cancer patients, Your Plan pays for dental services not otherwise covered. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth.

To obtain more information on how to access these medical Benefits, call Customer Service at the number on Your ID card, and ask to speak to a Case Manager.

Article 12. Your Benefits for Organ, Tissue, and Bone Marrow Transplants

Our Authorization is required to evaluate if You are suitable for all solid organ and bone marrow transplants and procedures. For this Plan, all autologous procedures are considered transplants.

Your Plan will not cover solid organ and bone marrow transplants unless You first receive written Authorization from Us. You or Your Provider must tell Us of the proposed transplant procedure before Admission and You must request for Authorization in writing. We must receive enough information to verify coverage, decide that Medical Necessity is documented, and approve of the hospital at which the transplant procedure will occur. We will send written Authorization to You and Your Providers.

A. Acquisition Expenses

If You receive a solid organ, tissue or bone marrow from a living donor for a covered transplant, Your Plan covers the donor's medical expenses as acquisition costs for the recipient.

If any organ, tissue or bone marrow is sold rather than donated to You, Your Plan does not cover the purchase price.

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Your Plan includes Benefits for solid organ and bone marrow transplants only when services are given by a Blue Distinction Centers for Transplants (BDCT) for the specific organ or transplant or a Blue Cross and Blue Shield of Louisiana Preferred Provider facility, unless We approve otherwise in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities. To find an approved transplant facility, call Customer Service at the number on Your ID card.

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

3. Your Plan covers immunosuppressive drugs prescribed for transplant procedures.

4. As specified in this section, Your Plan covers treatment and care as a result of or directly related to the following transplant procedures:

    a. Solid Human Organ Transplants of the:

(1) liver;

(2) heart;

(3) lung;

(4) kidney;

(5) pancreas;

(6) small bowel; and

(7) other solid organ transplant procedures which We decide 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. We will consider these solid organ transplants case by case.

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

Your Plan covers tissue transplants (other than bone marrow) under regular Benefits. They do not require prior Authorization. But, if an Inpatient Admission is required, it is subject to Article 16: *Care Management*.

Your Plan covers these following tissue transplants:

(1) blood transfusions;

(2) autologous parathyroid transplants;

(3) corneal transplants;

(4) bone and cartilage grafting;

(5) skin grafting;

(6) autologous islet cell transplants; and

(7) other tissue transplant procedures which We decide 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. We will consider these tissue transplants a case by case.

c. Bone Marrow Transplants

(1) Your Plan covers allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions.

(2) Other bone marrow transplant procedures which We decide 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. We will consider these bone marrow transplant procedures case by case.

Article 13. Your Benefits for Pregnancy Care and Newborn Care

Your Plan covers Pregnancy Care received from a Hospital, Physician, or Allied Health Provider if Your coverage is in effect when You receive the services for pregnancy.

We must Authorize a Hospital stay for childbirth for the covered mother or covered well newborn child only if the mother is in the Hospital more than 48 hours after a vaginal delivery or 96 hours after a caesarean section. We must Authorize a newborn's stay if it is longer than the mother's stay. We must Authorize a newborn's stay if a newborn is admitted separately because of neonatal Complications.

We have several maternity programs available to help pregnant Members deliver healthy babies. Call Customer Service at the number on Your ID card when You learn You are having a baby. When You call, We'll tell You about available programs.

A. Medical and Surgical Services

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

2. Diagnostic Services.

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

4. Medically Necessary abortions required to save the mother's life.

B. 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 Us, well newborn charges may be covered if the Member under this Plan is the father.

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

C. Newborn Care

For a newborn who is covered at birth as a Dependent:

1. Surgical and medical services that a Physician gives to treat illness, pre-maturity, post-maturity, or congenital condition of a newborn and circumcision. Your Plan covers Physician services for Inpatient Well Baby Care immediately after delivery until discharge.

2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, pre-maturity, post-maturity, 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. As determined by Us, well newborn charges may be covered if the Member under this Plan is the father.

D. 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 48 hours after a vaginal delivery, or less than 96 hours after a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (for example, Your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or Newborn earlier.

Also, under federal law, plans and issuers may not set the level of Benefits or Out-of-Pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or Newborn than any earlier portion of the stay.

Also, 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 48 hours or 96 hours. However, to use certain providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain prior Authorization.

For information on prior Authorization, contact Your Plan Administrator.

Article 14. Your Benefits for Rehabilitative and Habilitative Care

Your Plan covers Rehabilitative and Habilitative Care for services and devices provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation and Chiropractic Services. Your Plan covers these services and devices when a Provider who is licensed and practicing within the scope of that license gives them. For care to be considered at an Inpatient rehabilitation facility, You must be able to tolerate at least 3 hours of active therapy per day.

We must Authorize an Inpatient rehabilitation Admission before the Admission occurs. The rehabilitation must begin within 72 hours after discharge from an Inpatient Hospital Admission for the same or similar condition, unless otherwise approved by Us.

We may Authorize Day Rehabilitation Programs for Rehabilitative Care instead of Inpatient stays for rehabilitation. We must Authorize Day Rehabilitation Programs before You begin the program. The program must begin within 72 hours after discharge from an Inpatient Admission for the same or similar condition.

A. Occupational Therapy

1. Your Plan covers Occupational Therapy services when performed by a Provider licensed and practicing within the scope of that license, including 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. Before You receive services, Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist.

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

B. Physical Therapy

1. Your Plan covers Physical Therapy services when performed by a licensed physical therapist practicing within the scope of that license.

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

3. Before You receive services, Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor. But, if Physical Therapy is listed as a Covered service, You may receive it without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances:

    a. To children who have a diagnosed developmental disability according to Your plan of care.

    b. As part of a Home Health Care agency according to Your plan of care.

    c. To a patient in a nursing home according to Your plan of care.

    d. Related to conditioning or to providing education or activities in a wellness setting to prevent injury, reduce stress, or promote fitness.

    e. To someone for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the Provider diagnosed it. The diagnosis must have been made within the previous 90 days. Within the first 15 days of Physical Therapy intervention, the physical therapist must give the Provider who diagnosed the condition a plan of care for Physical Therapy services.

C. Speech/Language Pathology Therapy

1. Your Plan covers Speech/Language Pathology Therapy services when performed by a Provider who is licensed to practice in the state in which the services are given and who is practicing within the scope of that license, including a speech pathologist or by an audiologist.

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

3. Before receiving Speech/Language Pathology Therapy, a Physician must prescribe the services.

D. Chiropractic Services

1. Your Plan covers Chiropractic Services when performed by a chiropractor licensed and practicing within the scope of that license.

2. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices to rehabilitate a patient and may order diagnostic tests to determine conditions associated with the functional integrity of the spine.

Article 15. Your Benefits for Other Covered Services, Supplies, or Equipment

This Plan includes the following Benefits, subject to other limitations shown on the *Schedule of Benefits*.

A. Accidental Injury Benefits (if shown on the *Schedule of Benefits*)

If You incur medical expenses for treatment or services as a direct result of a traumatic bodily injury sustained only by accident, We will pay 100% of the Allowable Charge for those medical expenses up to the maximum amount per accident shown on the *Schedule of Benefits*. After We have paid the maximum, the Benefit Period Deductible Amount will apply and We will pay You regular Benefits.

This Plan does not pay for Benefits under this Accidental Injury Benefits section for services or supplies given for services or supplies provided under other sections of this Plan.

B. Acupuncture Benefits

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

C. Ambulance Service Benefits

1. Ground Ambulance Transport Services

   a. Emergency Transport

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

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

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

      (3) for the Temporarily Medically Disabled Mother of the ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, when the mother's attending Physician recommends that she needs professional Ambulance Service.

   b. Non-Emergency Transport

      Benefits for Ambulance Services are available for local transportation of Members for medical conditions that do not present an Emergency to obtain Medically Necessary Inpatient or Outpatient services when You are confined to a bed or Your condition requires that You not use any other method of transportation. 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.

      To be considered *confined to a bed*, You must be unable to qualify for non-Emergency transport:

      (1) get up from bed without assistance; and

(2) walk or move about freely; and

(3) sit in a chair or wheelchair.

c. Your Plan does not cover transport by wheelchair van.

2. Ground Ambulance Without Transport

Your Plan covers ambulance response and treatment at the scene, without transporting You to a facility for more medical care.

3. Air Ambulance Transport Services

a. Emergency Transport

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

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

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

b. Non-Emergency Transport

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

4. Ambulance Service Benefits will be provided as follows:

a. If You pay a periodic fee to an ambulance membership organization with which We do not have a Provider agreement, We will base Benefits for expenses You incur for its Ambulance Services on any obligation You must pay that the fee does not cover. If We have a Provider agreement with the ambulance organization, We will base Benefits 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. Your Plan does not cover transportation if it is for Your comfort or convenience.

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

D. Attention Deficit/Hyperactivity Disorder

Your Plan covers the diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder when a Physician or Allied Health Professional gives or prescribes them.

E. Autism Spectrum Disorders (ASD)

ASD Benefits include the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Habilitative or Rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Members who have not yet reached 21 years old are eligible for Applied Behavior Analysis, when We decide it is Medically Necessary. Your Plan does not cover Applied Behavior Analysis if You are 21 and older.

ASD Benefits are subject to the Copayments, Deductibles, and Coinsurance amounts. For example, if You have speech therapy to treat ASD, You will pay the Copayment, Deductible or Coinsurance amount shown on the *Schedule of Benefits* for speech therapy).

F. Breast Reconstructive Surgery Services and Breast Cancer Long-Term Survivorship Care

1. Under the Women's Health and Cancer Rights Act, a Member who is receiving Benefits in connection with a mastectomy resulting from breast cancer and elects breast reconstruction, You 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 the mastectomy, including lymphedemas.

These Covered Services must be delivered in a manner determined in consultation with the attending Physician and the Member and, if it applies, will be subject to any Deductible Amount, Copayment Amount and Coinsurance.

2. Certain breast cancer survivors are eligible to receive annual preventive cancer screening as part of long-term survivorship care. Members eligible for screening 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 Deductible Amount, Copayment Amount and Coinsurance.

G. Cleft Lip and Cleft Palate Services

Your Plan covers the following services to treat and correct Cleft Lip and Cleft Palate:

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.

Your Plan also covers secondary conditions and treatment attributable to the primary medical condition.

H. Clinical Trial Participation

1. This Plan covers any Qualified Individual for routine patient costs of items or services if you participate in an Approved Clinical Trial for cancer or other Life-Threatening Illness. Coverage will be subject to this Plan's terms, conditions and limitations, including Copayment, Deductible, or Coinsurance amounts shown on the *Schedule of Benefits*.
2. A *Qualified Individual* under this section means a Member who:
    a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol to treat cancer or other Life-Threatening Illness;
    b. And either,
        (1) The referring healthcare professional is a Participating Provider and has concluded that Your participation in a trial would be appropriate based on Your meeting the requirements in paragraph a, above; or
        (2) You provide medical and scientific information establishing that Your participation in the trial would be appropriate based on Your meeting the conditions described in paragraph a, above.
3. An *Approved Clinical Trial* for this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to preventing, detecting, or treating cancer or other Life-Threatening Illness that:
    a. One or more of the following organizations approves or funds (which may include funding through in-kind contributions) the study or investigation:

(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 entity described in paragraphs (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

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

b. The study or investigation is conducted under an investigational new drug application that the FDA reviewed.

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 Departments listed below, which study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines:

(1) to be comparable to the system of peer review of studies and investigations of the National Institutes of Health, and

(2) ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

(a) The Department of Veterans Affairs.

(b) The Department of Defense.

(c) The Department of Energy.

4. The Plan does not cover the following services:

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

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

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

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

5. If all of the following criteria are met, the Plan will cover treatments and associated protocol-related patient care not excluded in this paragraph:

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

b. The treatment is provided or the studies are 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.

I. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

a. If You have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes, You may need to be educated on Your condition and trained to manage Your condition. Your Plan covers self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if Your treating Provider prescribes them.

b. Your Plan covers evaluation and training programs for diabetes self-management subject to the following:

(1) The program must be prescribed by Your treating Provider and a licensed healthcare professional must certify that You have successfully completed the training program.

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

2. Diabetic Retinal Screening

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

J. Dietitian Visits

Your Plan covers visits to registered dietitians. One dietitian visit is covered at no cost to Members when performed by a Network Provider. All other subsequent dietitian visits are covered at plan Benefits. If You are diabetic and You need the services of a dietitian, Your Plan covers those services under Diabetes Education and Training for Self-Management.

K. Disposable Medical Equipment and Supplies

Your Plan covers disposable medical equipment or supplies which have a primary medical purpose, subject to reasonable quantity limits that We set. The equipment and supplies are subject to Your medical Deductible Amount and Coinsurance.

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

Your Plan covers Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) at the Coinsurance shown on the *Schedule of Benefits*.

1. Durable Medical Equipment

   a. Your Plan covers Durable Medical Equipment when the equipment a Physician prescribes it before You obtain it. The equipment must not be mainly for comfort or convenience. Also, the equipment must meet all of the following criteria:

      (1) It must withstand repeated use;

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

      (3) It is generally not useful to someone who is not ill or injured; and

      (4) It is appropriate for use in Your home.

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

      (1) We will base Benefits for renting Durable Medical Equipment on the rental Allowable Charge (but not more than the purchase Allowable Charge).

      (2) We may choose to offer Benefits for buying Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. We will base the Benefit on the purchase Allowable Charge.

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

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

         (a) that do not serve a medical purpose;

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

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

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

      (4) We consider accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment to be an integral part of the rental or purchase allowance. Your Plan will not cover them separately.

      (5) Your Plan covers repairing or adjusting purchased Durable Medical Equipment or replacing components. Your Plan will not cover replacing equipment that is lost or replacement of equipment damaged due to neglect or misuse. Replacing equipment within 5 years after purchase or rental that is not Medically Necessary, as defined in this Plan, will not be covered. Repair, adjustment, or replacement of equipment will not be covered when provided under warranty.

   c. Limitations for Durable Medical Equipment.

(1) Your Plan does not cover renting Durable Medical Equipment for repairing, adjusting, or replacing components and accessories necessary to effectively function and maintain covered equipment because the Durable Medical Equipment supplier must pay for that.

(2) Your Plan does not pay for equipment where a commonly available supply or appliance can effectively serve the same purpose.

(3) Your Plan does not pay for replacing equipment that is lost. Your Plan does not pay for repair or replacement of equipment damaged due to neglect or misuse.

(4) We will decide the reasonable quantity limits on Durable Medical Equipment items and supplies.

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

2. Orthotic Devices

As specified in this section, Your Plan will cover buying Orthotic Devices that We Authorize. These Benefits will be subject to the following:

a. Your Plan does not pay for fitting or adjustments because these are included in the Allowable Charge for the Orthotic Device.

b. Your Plan only pays to repair or replace Orthotic Device within a reasonable time period after the date You buy it subject to the expected lifetime of the device. We will decide this time period. Repair or replacement of the device will not be covered when provided under warranty.

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

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

(a) that do not serve a medical purpose;

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

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

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

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

d. Your Plan does not pay for supportive devices for the foot, except when used to treat diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

Your Plan will cover buying Prosthetic Appliances and Devices (other than limb prosthetics and services) that We Authorize and that are covered according to the following:

a. Your Plan does not pay for fitting or adjustments because these are in the Allowable Charge for the Prosthetic Appliance or Device.

b. Your Plan only pays to repair or replace Prosthetic Appliance or Device within a reasonable time period after the date You buy it subject to the expected lifetime of the appliance. We will determine this time period. Repair or replacement of appliances or devices will not be covered when provided under warranty.

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

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

(a) that do not serve a medical purpose;

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

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

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

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

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

Your Plan will pay to buy Prosthetic Appliances and Devices and Prosthetic Services of the limbs that We Authorize, and are covered subject to the following:

a. Your Plan pays to repair or replace the Prosthetic Appliance or Device only within a reasonable time period after the date You buy it, subject to the expected lifetime of the appliance. We will decide this time period. Repair or replacement of appliances or devices will not be covered when provided under warranty.

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

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

(a) that do not serve a medical purpose;

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

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

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

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

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

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

M. Erectile Dysfunction Benefits

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

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

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

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

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

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

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

N. 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.

O. Genetic or Molecular Testing for Cancer

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

P. Hearing Benefits

1. Your Plan covers hearing aids if You are 17 years old or younger when You go to a Network Provider or another Provider that We approve. This Benefit is limited to 1 hearing aid for each ear with hearing loss every 36 months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or hearing aid dealer after the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

   We will pay up to Our Allowable Charge for this Benefit. We may increase Our Allowable Charge if the manufacturer's cost to the Provider is more than the Allowable Charge.

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

Q. High-Tech Imaging

Your Plan covers Medically Necessary High-Tech Imaging, including but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology. We must Authorize these services before You receive them.

R. Home Health Care

Your Plan covers Home Health Care services provided to You instead of an Inpatient Hospital Admission, covered. Coverage may be limited if shown on the *Schedule of Benefits*.

S. Hospice Care

Hospice Care is covered.

T. Interpreter Expenses for the Deaf or Hard of Hearing

Your Plan covers the services of a qualified interpreter or transliterator:

1. when You need services for medical treatment or diagnostic consultations; and

2. if the services are required because of hearing loss or You do not understand or cannot communicate in spoken language.

Your Plan does not pay for these services if a family member gives them, or if it does not pay for the medical treatment or consultation.

U. Low-Protein Food Products to Treat Inherited Metabolic Diseases

Your Plan covers low-protein food products to treat certain Inherited Metabolic Diseases. *Inherited Metabolic Disease* is a disease caused by an inherited abnormality of body chemistry. *Low-Protein Food Products* are especially formulated to have less than1 gram of protein per serving and are intended to be used under the direction of a Physician to treat an Inherited Metabolic Disease. Low-Protein Food Products do not include natural foods that are naturally low in protein.

Benefits for Low-Protein Food Products are limited to treat the following diseases:

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

V. Lymphedema Benefit

Your Plan pays to treat lymphedema when given by or prescribed by a licensed Physician or received in a Hospital or other public or private facility authorized to provide lymphedema treatment. Coverage includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

W. Permanent Sterilization Procedures

Your Plan covers surgical procedures that result in permanent sterilization, including vasectomy, tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes unless the *Schedule of Benefits* shows that they are not covered. If covered, Your Plan pays for tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes as a Preventive or Wellness Care Benefit.

X. Prescription Drugs

If Your Plan pays for Prescription Drugs, all Prescription Drugs approved for self-administration (for example, oral and self-injectable drugs) must be obtained through the Prescription Drug Benefits section of this Plan.

Y. Private-Duty Nursing Services

1. Your Plan covers Private-Duty Nursing Services when they are performed on an Outpatient basis and when the nurse is not related to You by blood, marriage, or adoption.

2. Your Plan covers Private-Duty Nursing Services subject to the Deductible Amount and Coinsurance shown on the *Schedule of Benefits*.

3. Your Plan does not pay for Inpatient Private-Duty Nursing Services.

Z. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Your Plan only covers sleep studies performed as a home sleep study or in a network-accredited sleep laboratory. See Your provider directory or call Customer Service at the number on Your ID card to check that a sleep laboratory is accredited.

AA. 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 Member and Provider may take place in different ways, depending on the circumstances, but this interaction must always be suitable for the setting in which the Telehealth Services are provided.

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

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

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.

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

In general, there is no coverage for Telehealth Services 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 Us.

BB. Temporomandibular Joint Syndrome (TMJ)

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

Article 16. Care Management

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

1. Selection of Provider

   Generally, You may go to any Provider. We will pay Benefits at the highest Network level when You go to a Network Provider. *Participating* and *Non-Participating Providers* are Non-Network Providers.

   a. If You want to go to a Participating or Non-Network Provider and receive the highest level of Benefits, You must notify Care Management before You receive services. We will approve going to a Participating or Non-Network Provider only if We decide that the services cannot be provided by a Network Provider within a 75-mile radius of Your home.

      We must approve going to a Non-Network Provider before You receive services. If We do not approve going to a Non-Network Provider and do not issue an Authorization, We will pay for Covered Services that are later decided to be Medically Necessary at the lower Non-Network Provider level shown on the *Schedule of Benefits*.

   b. If We do approve going to a Non-Network Provider, that Provider may or may not accept Your Copayment or Deductible Amount when You receive services. We will pay Benefits up to the Allowable Charge for Covered Services if You go to an approved Non-Network Provider and have received any Authorizations before You go. We will deduct from Our payment the amount of Your Copayment or Deductible Amount and Coinsurance whether or not the Non-Network Provider accepts the percentage.

An Authorization of Medical Necessity does not mean that We approve for You to go to a Non-Network Provider. These are separate.

2. Penalties if You do not receive Our Authorization – Admissions, Outpatient Services and Other Covered Services and Supplies

   If You do not ask for an Authorization before Admission or before You receive other Covered Services and supplies that require an Authorization, We can decide if the Admission or other Covered Services and supplies were Medically Necessary. If the services were not Medically Necessary, Your Plan will not cover the Admission or other Covered Services and supplies. You must pay all charges.

   If the services were Medically Necessary, We will base Benefits on the participating status of the Provider who gave the services, as follows:

a. Admissions

(1) If a Network Provider or a Participating Provider does not receive Authorization, We will reduce Allowable Charges by the penalty amount shown 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 is responsible for all charges not covered. You must pay any Copayment or Deductible Amount and Coinsurance shown on the *Schedule of Benefits*.

(2) If a Non-Participating Provider does not receive Authorization, We will reduce Allowable Charges by the amount shown on the *Schedule of Benefits*. This penalty applies to all covered Inpatient charges. You must pay all charges not covered and for any Copayment, Deductible Amount and Coinsurance shown on the *Schedule of Benefits*.

b. Outpatient Services, Other Covered Services and Supplies

(1) If a Network Provider does not receive Authorization, We may reduce the Allowable Charge by 30%. This penalty applies to all services and supplies that require an Authorization, other than Inpatient charges. The Network Provider is responsible for all charges not covered. You must pay Your Copayment or Deductible Amount and Coinsurance.

(2) If a Non-Network Provider does not receive Authorization, Benefits will be paid at the lower Non-Network level shown on the *Schedule of Benefits*. You must pay all charges not covered and Your Copayment, Deductible Amount and Coinsurance.

3. Authorization of Admissions

a. Authorization of Elective Admissions

You must ensure that Your Provider notifies Our Care Management Department of any Elective or non-Emergency Inpatient Hospital Admission. Before the Admission, You must call Us at the number shown on the *Schedule of Benefits* or Your ID card about the nature and purpose of any Elective Admission or non-Emergency Admission to a Hospital's Inpatient department. We will decide the most appropriate setting for the elective service and the appropriate length of stay 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, Your Plan will not pay for the Admission; You must pay all charges.

(2) If You do not request Authorization before an Admission, We can decide if the Admission was Medically Necessary. If an Admission was Medically Necessary, Your Plan will pay based on Your Provider's participating status.

Your Plan does not pay for additional amounts that You must pay because We denied an Authorization or it was not requested. Those amounts will not apply toward the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

You must ensure that Your Physician, or Hospital, or representative notifies Our Care Management Department of all Emergency Admissions. Within 48 hours of the Emergency Admission, You must tell Us about the nature and purpose of the Emergency Admission. Call Us at the number shown on the *Schedule of Benefits* or on Your ID card. We may waive or extend this time limitation if We decide that

You cannot notify Us on time or cannot direct Your representative to notify Us of the Emergency Admission. If the end of the notification period falls on a holiday or weekend, You must notify Us on the next working day. We will decide the appropriate length of stay for the Emergency Admission when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If We deny Authorization for an Admission to any facility, Your Plan will not pay for the Admission; You must pay all charges.

(2) If You do not request Authorization, We have the right to decide if the Admission was Medically Necessary. If an Admission was Medically Necessary, Your Plan will pay Benefits based on the Provider's participating status.

(3) Your Plan does not pay additional amounts that You must pay because We denied Authorization or it was not requested. Those amounts will not apply toward the Out-of-Pocket Amount.

c. Concurrent Review

When We Authorize Your Inpatient stay, We will Authorize Your stay for a certain number of days. If You have not been discharged on or before the last Authorized day, and You need more days to be Authorized, You must make sure Your Physician or Hospital contacts Our Care Management Department to ask for Concurrent Review to Authorize more days. This request for continued hospitalization must be made on or before Your 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 You are either discharged or We deny Your request for continued stay.

(1) If We do not receive a request for Authorization for continued stay on or before Your last Authorized day, no days are approved after the last Authorized day, and Your Plan will not pay for more Benefits unless We receive and Authorize another request. If at any point in this Concurrent Review procedure We receive a request for Authorization for continued stay and We decide that it is not Medically Necessary for You to receive continued hospitalization or hospitalization at the level of care requested, We will write to You and Your Providers that We deny the request and do not Authorize more days.

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

(3) Your Plan does not pay for charges for non-Authorized days in the Hospital that You must pay. The charges will not apply toward satisfying the Out-of-Pocket Amount.

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

We must Authorize certain services, supplies, and Prescription Drugs before You receive them. For the Authorizations list, see Your *Schedule of Benefits*.

You must make sure that Your Provider obtains all required Authorizations before You receive the services, supplies, or Prescription Drugs. We may need Your Provider to submit medical or clinical information about Your condition. To obtain Authorizations, Your Provider should call Care Management at the number on Your ID card.

a. If We deny a request for Authorization, Your Plan does not pay for the Outpatient services and supplies.

b. If Authorization is not requested before receiving Outpatient services and supplies requiring Authorization, We have the right to decide if the services or supplies were Medically Necessary. If they were Medically Necessary, Your Plan will pay based on the Provider's participating status.

B. Disease Management

1. **Qualification** - At Our discretion, You may qualify for Disease Management programs based on various criteria, including a diagnosis of chronic illness, severity, and proposed or received treatment. The disease management program tries to identify candidates as early as possible. The program reinforces self-management techniques and assigns a personal nurse. You, Your Physicians, and caregivers may be included in all phases of the program. The nurse may also refer You to community resources for more support and management.

2. **Disease Management Benefits** – Our Disease Management programs improve the quality of care for You as well as decrease healthcare costs for people who have chronic diseases. The nurse works with You to help You learn self-care techniques to manage chronic disease, establish realistic goals for lifestyle modification, and improve adherence to Your Physician-prescribed treatment plan. We are dedicated to supporting the Physician's efforts in improving Your health status and well-being.

C. Case Management

1. At Our discretion, You may qualify for Case Management Services based on various criteria including diagnosis, severity, length of illness, and proposed or received treatment. The case management program tries to identify candidates as early as possible and to work with them, their Physicians, their families, and other community resources to assess treatment alternatives and available Benefits.

2. The role of Case Management is to service You by assessing, facilitating, planning and advocating for Your health needs. Many clients benefit from Case Management, including people in an acute phase of illness or with a chronic condition.

3. Our decision that Your medical condition makes You suitable for Case Management services will not obligate Us to make the same or similar determination for You or for any other Member. Because We provide Case Management services to one Member, that does not entitle any other Member to Case Management services and We do not waive Our right to administer and enforce this Plan according to its express terms.

4. Unless We expressly agree, all terms and conditions of this Plan, including maximum Benefit limitations and all other limitations and exclusions, will be and remain in full force and effect if You receive Case Management services.

5. Your Case Management services will end when any of the following occur:

   a. In Our sole discretion, We decide that You are no longer suitable for the Case Management services or that You no longer need them.

   b. The short- and long-term goals set in the Case Management plan have been achieved, or You choose not to participate in the Case Management plan.

D. Alternative Benefits

1. At Our discretion, You may qualify for Alternative Benefits based on various criteria, including diagnosis, severity, length of illness, and proposed or received treatment. The Alternative Benefits program tries to

identify candidates as early as possible and to work with them, their Physicians, their families, and other community resources to assess treatment alternatives and available Benefits when We decide it to be beneficial to You and to Us.

2. Our decision that Your medical condition makes You suitable for Alternative Benefits will not obligate Us to make the same or similar determination for any other Member. Because We provide Alternative Benefits to one Member, that does not entitle any other Member to Alternative Benefits and We do not waive Our right to administer and enforce this Plan according to its express terms.

3. Unless We expressly agree, all terms and conditions of this Benefit Plan, including maximum Benefit limitations and all other limitations and exclusions, are in full force and effect if You are receiving Alternative Benefits.

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

5. Your Alternative Benefits will end when any of the following occur:

   a. We determine, in Our sole discretion, that You are no longer suitable for the Alternative Benefits or that You no longer need Alternative Benefits.

   b. You receive care, treatment, services, or supplies for the medical condition that are excluded under this Plan, and that are not specified as Alternative Benefits We approve.

Article 17. When Won't the Plan Pay? Limitations and Exclusions

A. This Plan Does Not Cover Certain Services, Surgeries Supplies, and Treatments

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

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

B. We May Delete or Revise Limitations or Exclusions in this Plan

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

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

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

2. Any charges more than 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. This Plan does not pay for services that You do not have to pay, or for which no charge or a lesser charge would be made if You had no health insurance. Your Plan pays when You receive Covered Services at medical facilities that are owned and operated by the State of Louisiana or any of its political subdivisions;

   b. given before Your Effective Date or after Your coverage ends, except as follows: Your Plan will pay Medical Benefits in connection with an Inpatient Hospital Admission for an Admission in progress on the date Your coverage ends, until the end of that Admission or until You reach any Benefit limitations set in this Plan, whichever occurs first;

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

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

   e. paid or payable under Medicare Parts A or B when You have Medicare, except when Medicare Secondary Payer provisions apply;

   f. which are Investigational, except as specifically provided in this Plan. We make Investigational determinations according to Our policies and procedures;

   g. rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs, including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes whether or not coverage under such laws or programs is actually in force. This exclusion shall not apply to services rendered to a Member holding ten (10%) percent or more ownership in the Group, if the Member has done all of the following: (1) legally opted to be excluded from workers' compensation coverage for the Group by entering into a written agreement with Group's workers' compensation carrier electing not to be covered by such coverage; (2) properly enrolled with Company in owner 24-hour health coverage; (3) furnished the Company with a copy of the written agreement between the Member and the workers' compensation carrier; (4) furnished the Company with written evidence of Member's ownership interest in Group. If this information is not submitted to Company at the time of Member's initial enrollment for health coverage, or upon acquisition of the required ownership percentage, then Member may enroll for this coverage at Member's next open enrollment opportunity;

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

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

   j. for telephone calls, video communication, text messaging, e-mail messaging, instant messaging, or patient portal communications between You and your Provider unless specifically stated as covered

under the Telehealth Services Benefit; for services billed with Telehealth codes not suitable for the setting in which the services are provided; for Telehealth Services not permitted by Us; and for Telehealth Services rendered by Providers not permitted by Us;

k. for 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 our enrollment in or with any Provider;

l. for services performed in the home unless the services meet the definition of Home Health, or otherwise covered specifically in this Plan, or are approved by Us;

m. 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 because You took part in a riot or acts of civil disobedience;

d. those occurring because You committed or tried to commit a felony.

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

6. **REGARDLESS OF CLAIMS 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, 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. diastasis recti;

g. biofeedback;

h. lifestyle or habit-changing clinics or programs, except those the law requires Us to cover and those We offer, endorse, approve, or promote, as part of Your coverage under this 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;

i. Diabetes prevention programs unless approved by Us and limited to once every thirty-six (36) months;

j. 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;

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

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

m. industrial testing or self-help programs including stress management programs, work-hardening programs or functional capacity evaluation; driving evaluations, etc., except services that the law requires Us to cover;

n. recreational therapy;

o. Inpatient pain rehabilitation and Inpatient pain control programs; and

p. primarily to enhance athletic abilities.

7. **REGARDLESS OF CLAIMS 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 or exams (except for the initial pair and fitting of eyeglasses or contact lenses required after cataract Surgery), unless shown as covered in this Plan or on the *Schedule of Benefits*;

   b. eye exercises, visual training, or orthoptics;

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

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

   e. the correction of refractive errors of the eye, including radial keratotomy and laser Surgery; or

   f. visual therapy.

8. **REGARDLESS OF CLAIMS 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 You are a donor except as provided in this Plan;

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

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

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

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 Company prior to services being rendered.

9. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for any of the following, except as specifically provided in this Plan or in the *Schedule of Benefits*:

   a. weight-reduction programs;

   b. bariatric Surgery procedures including, but not limited to:

      (1) Roux-en-Y gastric bypass

      (2) Laparoscopic adjustable gastric banding

      (3) Sleeve gastrectomy

      (4) Duodenal switch with biliopancreatic diversion;

   c. removal of excess fat or skin, or services at a health spa or similar facility; or

   d. obesity or morbid obesity, except as required by law.

10. **REGARDLESS OF CLAIMS 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 Plan.

11. Benefits are excluded for Prescription Drugs that We decide are not Medically Necessary to treat illness or injury. Your Plan does not cover the following unless the *Schedule of Benefits* shows that they are covered:

    a. lifestyle-enhancing drugs including 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, or medications used to enhance athletic performance;

    b. medications for obesity, weight loss, weight management, or weight maintenance (e.g., Contrave®, Qsymia®, Saxenda®, Wegovy™);

    c. any drug not proven effective in general medical practice;

    d. Investigational drugs and drugs used other than for the FDA-approved indication along with all Medically Necessary services associated with the administration of the drug, except drugs that FDA has not approved for a particular indication but that are recognized to treat the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least 2 peer-reviewed national professional medical journals or the drug is expected to provide a similar clinical outcome for the covered indications as those included in nationally accepted standards of medical practice as determined by Us;

    e. fertility drugs;

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

g. prescription vitamins not listed as covered in the Prescription Drug Formulary (including but not limited to, Enlyte);

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

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

j. refills that are more than the number specified by the Physician or the dispensing limitation described in this Plan, or a refill before 75% of day supply used, or any refills dispensed more than 1 year after the date of the Physician's original prescription;

k. compounded drugs that exhibit any of the following characteristics:

   (1) are similar to a commercially available product;

   (2) whose principal ingredients are being used for an indication for which no FDA approval exists;

   (3) whose principal ingredients are being mixed together to administer in a manner inconsistent with FDA-approved labeling (for example, 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 safety reasons; or

   (5) compounded prescriptions whose only ingredients do not require a prescription;

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

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

n. Prescription Drug compounding kits;

o. selected Prescription Drug products that are packaged in a way that contains more than one (1) Prescription Drug;

p. selected Prescription Drug products with multiple therapeutic alternatives, which may be available in a greater or lesser strength or different dosage form (e.g., tablet, capsule, liquid, suspension, extended release, tamper resistant);

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

r. Prescription Drugs filled before Your Effective Date or after Your coverage ends;

s. replacement of lost or stolen Prescription Drugs, or those that are useless because of mishandling, damage or breakage;

t. Prescription Drugs, equipment or substances to treat sexual dysfunction, low sexual desire disorder (Addyi®) or other sexual inadequacies;

u. Prescription Drugs, equipment or substances to treat Erectile Dysfunction (e.g., Viagra®, Cialis®, Levitra®) for Members who are not age eighteen (18) or older;

v. medication, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used illegally;

w. growth hormone therapy, except to treat 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 growth hormone deficiency with abnormal provocative stimulation testing;

x. Prescription Drugs to treat idiopathic short stature;

y. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers at the same time, where a prescriber agrees prescriptions were obtained through Member misrepresentation to that prescriber. Limitations may include, but are not confined to, requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy;

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

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

bb. Prescription Drugs approved for self-administration (for example, oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider unless the provider is contracted with Our Pharmacy Benefit Manager;

cc. covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration as We decide are covered under the medical Benefit and not covered under the Pharmacy Benefit; and

dd. sales tax or interest including sales tax on Prescription Drugs. Any sales tax on Prescription Drugs will be included in the cost of the Prescription Drugs when We figure Your Coinsurance and how much We pay. We will pay for the sales tax for eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Your Copayment. In that case, You must pay the Prescription Drug cost and sales tax.

12. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for personal comfort, personal hygiene and convenience items including air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to Your home or vehicle.

13. **REGARDLESS OF CLAIMS 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 people who have been diagnosed with diabetes when those services are Medically Necessary.

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

15. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for services or supplies related to diagnosing and treating Infertility including 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, Your Plan does not pay for these procedures.

16. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for services, supplies or treatment related to artificial means of Pregnancy including 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 CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for prenatal and postnatal services or supplies of a Gestational Carrier including Hospital, Surgical, Mental Health, pharmacy or medical services.

18. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.

19. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for services, supplies or treatment for cosmetic purposes, Cosmetic Surgery and any Complications of Cosmetic Surgery, unless required for Congenital Anomaly or Mastectomy.

20. **REGARDLESS OF CLAIMS 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.

21. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Plan under Oral Surgery Benefits. This exclusion does not apply to Cleft Lip and Cleft Palate coverage.

22. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for diagnosis, treatment, or surgery of dentofacial anomalies including malocclusion, hyperplasia or hypoplasia of the mandible or maxilla, and any orthognathic condition, except as required by law. This exclusion does not apply to Cleft Lip and Cleft Palate coverage.

23. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for medical exams and 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 Plan.

24. **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 Us.

25. **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.

26. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for educational services and supplies, training or re-training for a vocation, or diagnosing, testing, or treating remedial reading, dyslexia and other learning disabilities. This includes Applied Behavior Analysis (ABA) services that are not habilitative treatment and specifically target academic or educational goals; and para-professional or

shadowing services used as maintenance 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 U.S. Preventive Services Task Force recommendations that the law requires Us to cover.

27. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Applied Behavior Analysis (ABA) that the Company has 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.

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

29. **REGARDLESS OF CLAIMS 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 the law requires Us to cover.

30. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for hospital charges for a well newborn.

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

32. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for surgical and medical treatment for snoring without obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).

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

34. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as We decide. Your Plan does not pay for portable defibrillators. Your Plan covers implantable defibrillators and wearable defibrillators when We Authorize them.

35. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a member related to:

    a. Genetic testing, unless the results are specifically required for a medical treatment decision on You or as the law requires;

    b. Pre-implantation genetic diagnosis;

    c. Preconception carrier screening; and

    d. Prenatal carrier screening except screenings for cystic fibrosis.

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

37. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for sleep studies, unless performed as a home sleep study or in a network-accredited sleep laboratory. If a sleep study is not performed by a network-accredited sleep laboratory, as a home sleep study or We deny a sleep study, then Your Plan does not pay for the study or any professional Claims associated with it.

Article 18. Your Rights to Continue Coverage

A. The Surviving Spouse May Continue Coverage

If eligibility for Group coverage ends when the Subscriber dies, and You are a surviving Spouse who is 50 years old or older, You have 90 days from the date the Subscriber dies to notify Us that You want to continue the same coverage for Yourself, and if they are already covered, for Your Dependent children.

Coverage is automatic during the 90-day election period. You must pay Your Premium for this coverage. If You do not choose to continue, or if We do not receive Your Premium for the automatic coverage, Your automatic coverage ends retroactively to the end of the billing cycle in which the Subscriber died.

If You choose to continue coverage within the 90-day period, coverage will continue without interruption. You owe the Premium is owed from the last date for which Premium has been paid. No physical exams are required. Your Premium for continuing coverage will not be more than the premium assessed for each Subscriber by class of coverage under the Plan.

The Group must notify the Spouse of the right to continue and to bill and collect the Premiums. But, if We have the home address of the surviving Spouse when the Subscriber dies and the Group has notified Us in an acceptable manner, We will notify the surviving Spouse of the right to continue.

Coverage continues on a premium-paying basis until the earliest of:

- the date premium is due and is not paid on time; or
- the date the surviving Spouse or a Dependent child becomes eligible for Medicare; or
- the date the surviving Spouse or a Dependent child becomes eligible for another Group health plan; or
- the date the surviving Spouse remarries or dies; or
- the date this Group Benefit Plan ends; or
- the date a Dependent child is no longer eligible.

B. State Continuation

This section is available only if the Group is not subject to Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any of its amendments.

A Subscriber or covered Dependent whose coverage under this Plan ends because:

- the Subscriber dies; or

- the Subscriber's active employment ends; or
- of the divorce of the Subscriber or a Member, may be entitled to continue this coverage.

The Subscriber or Dependent requesting continuation must have been continuously covered under this Plan (or another group policy that this Plan replaced) for the 3 months in a row immediately before the date this coverage would otherwise have ended.

A Subscriber or Dependents cannot continue coverage if:

- within 31 days of termination of coverage, the Covered Person is or could have been covered by other Group coverage or a government-sponsored health plan such as Medicare or Medicaid, or Group; or
- the Subscriber's or Member's coverage under this Plan ended because of fraud or failure to pay the required contribution to premium; or
- the Covered Person is eligible to continue coverage under COBRA.

To elect continuation of coverage under this section, if You are the Subscriber or Member, You must write to the Group that You want to continue this Group health coverage and You must pay any required contribution to the Group before then. You must pay the first contribution no later than the end of the month after the month in which the event occurred that made You eligible. (If the Dependent is eligible due to divorce, the event will be deemed to have occurred on the date of the judgment of divorce.) For the form to continue coverage, contact the Group.

Continuation of insurance under the Group policy for any Covered Person must terminate on the earliest of the following dates:

- 12 calendar months from the date coverage would have otherwise ended; or
- the date ending the period for which the Subscriber or Dependent makes his last required premium contribution for the coverage; or
- the date the Subscriber or Member becomes or is eligible to become covered for similar Benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured, including Medicare or Medicaid; or
- the date on which the Group policy is terminated; or
- the date on which an enrolled Member of a health maintenance organization legally resides outside Our service area.

C. COBRA Continuation Coverage

The following provisions apply only if the Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto. See the Group Human Resources Manager or Benefits Manager for details about COBRA, or the applicability of COBRA to this Plan.

What is COBRA continuation coverage?

According to 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 called a *qualifying event*) that would otherwise result in the loss of coverage under the Employer's plan. When a qualifying event causes such loss of coverage, COBRA continuation coverage must be offered to

each person who is a *qualified beneficiary*. The Subscriber, the Subscriber's Spouse and the Subscriber's dependent children are listed under the law as the qualified beneficiaries. COBRA continuation coverage offers the same coverage that the Plan gives to other participants or beneficiaries who are not receiving continuation coverage. The qualified beneficiary may be required to pay the full cost of the continuation coverage for its entire duration.

Do I have other alternatives to COBRA continuation coverage?

COBRA continuation coverage is not the only alternative You may have when they lose coverage under this Plan. You and Your family may have other coverage options.

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 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.

Also, You may qualify for a special enrollment opportunity for another group 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 30 days from losing coverage under this Plan.

Therefore, consider all Your options so You choose the one that better fits Your needs and budget.

What if I choose to get COBRA continuation coverage?

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

What are the *qualifying events*?

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

- termination of employment of a covered Employee for reasons other than gross misconduct;
- loss of eligibility by a covered Employee due to a reduction in the number of work hours of the Employee;
- death of a covered Subscriber;
- divorce or legal separation between Subscribers and their Spouses;
- the Subscriber becomes entitled to Medicare Benefits resulting in the loss of coverage for Dependents;
- a Dependent child is no longer an Eligible Dependent under the terms of this Plan; or
- the Employer files for a Chapter 11 bankruptcy, 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 that case, certain retirees may choose lifetime COBRA coverage. Eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may choose 36 more 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 end early for a number of reasons including: the Employer ceases to provide any group plan to any Employees or the qualified beneficiaries fail to pay the required premiums or become covered under another Employer's group 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 decided 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?

Within 60 days of the event, the qualified beneficiary must notify the Group of the following:

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

The Group will advise qualified beneficiaries of their rights under COBRA when any qualifying event occurs or after 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 give it to the Group on time. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which You would otherwise lose coverage under the Group's plan (the *coverage end date*); and
- ends 60 days after the coverage end date or 60 days after You are notified of Your right to continue coverage, whichever is the latest.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the Employee's Spouse may elect continuation coverage even if the Employee does not. Continuation coverage may be elected for only one, several or for all Dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of the Dependent children. The Employee or the Employee's Spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

How much will I have to pay for COBRA continuation coverage?

A Member may be required to pay the entire cost of continuation coverage (including both Employer and Employee contributions) plus an amount to cover administrative expenses. If continuation of coverage is elected, the qualified beneficiary must make his first payment for continuation coverage within 45 days after the date of the election. If the qualifying beneficiary does not make the correct first payment in full within the 45-day period, all COBRA continuation coverage rights are lost. Timely monthly payments are required thereafter to keep coverage. Member may not receive notice of payments due.

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

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

- 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 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 36 months from the date of Medicare entitlement or 18 months from the qualifying event; or
- 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 36 months from the qualifying event. This maximum duration period cannot be extended, regardless of the circumstances.

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

If a qualified beneficiary experiences a second qualifying event other than the termination of employment or reduction of work hours while receiving 18 months of COBRA continuation of coverage, the Dependents who were qualified beneficiaries when the first qualifying event occurs, and elected COBRA continuation coverage, may qualify for up to 18 more months of continuation of coverage, up to 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 Plan as a Dependent.

The second qualifying event applies 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 60 days after the date of a second qualifying event to extend the COBRA continuation coverage.

The 18 months of continuation coverage may also be extended to a maximum of 29 months if a qualified beneficiary is disabled at some time during the first sixty (60) days of COBRA coverage and is determined to be

disabled (as determined under Title II, or XVI of the Social Security Act) by the Social Security Administration during the original eighteen (18) months of COBRA coverage.

This 11-month extension is available to all eligible people who are qualified beneficiaries and elected COBRA continuation coverage for the original 18 months. The qualified beneficiary must notify the Group of the disability determination before the end of the initial 18-month COBRA period and within sixty (60) days from the date of the notice from the Social Security Administration of the determination of disability.

The qualified beneficiary must also notify the Group within 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 29 months after the date of the qualifying event or the first day of the month that begins more than 30 days after a final determination that the qualified beneficiary is no longer disabled, subject to the original 18 months of COBRA coverage.

D. Tell the Group About Address Changes

To protect You and Your family's rights, You should keep the Group informed of any changes in Your address and the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Group Plan Administrator.

E. 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 choose to continue coverage under this Plan for up to 24 months after the date that the Employee leaves for service. Only covered Employees may choose to continue coverage under USERRA for themselves and for eligible Dependents who were covered under the Plan immediately before they left for military service. Dependents cannot independently choose USERRA continuation coverage.

To claim USERRA continuation coverage, Employees must properly notify their Employers that they are leaving to perform *service in the uniformed services* and apply for continuation coverage as the Employers require.

Employees who choose USERRA continuation coverage may have to pay Premiums. If the leave of absence lasts 30 days or less, You may have to pay Your required contribution for coverage. But, if the military leave of absence lasts more than 30 days, You may have 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:

- You do not pay the required Premiums on time, or
- The day after the date on which the law requires You to apply for or return to a position of employment and You do not do so.

Employers subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may choose to provide USERRA continuation coverage rights at the same time as COBRA continuation coverage, as the law allows. Each Employer acts independently in choosing how to apply this provision; it does not reflect any of Our guidelines. In all cases, consult Your Employer on how this provision applies to Your Plan.

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

Article 19. Coordination of Benefits

A. Applicability

1. This Coordination of Benefits ("COB") section applies to This Plan when a Member 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 person.

   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 person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

      (2) If a person is covered by two or more Plans that compute their Benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified Benefit is not an Allowable Expense.

      (3) If a person is covered by two or more Plans that provide Benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

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

      (1) If a person is covered by one Plan that calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its Benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans.

      (2) The amount of any Benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan

provisions include second surgical opinions, prior Authorization of Admissions, and Preferred Provider arrangements.

2. “Closed Panel Plan” a Plan that provides health Benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes Benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

3. *“*Coordination of Benefits or COB Provision” the part of the Benefit Plan providing the health care 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 health care 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 person has health care 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;

      (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 person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

   a. The Primary Plan pays or provides its Benefits according to its terms of coverage and without 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 Non-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 person other than as a Dependent, for example as an Employee, Member, policyholder, Subscriber or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare Beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g., a retired Employee); then the order of Benefits between the two Plans is reversed so that the Plan covering the person 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 (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 (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 (1) or (2) above shall determine the order of Benefits as if those individuals were the parents of the child.

(4) For a Dependent child covered under the spouse's Plan:

(a) For a Dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a Dependent under a spouse's Plan, the Longer or Shorter Length in Coverage Rule 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 (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 person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this 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) can determine the order of Benefits.

d. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, Member, Subscriber or retiree or covering the person as a Dependent of an Employee, Member, Subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this 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) determine the order of Benefits.

e. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an Employee, Member, policyholder, Subscriber or retiree longer is the Primary Plan and the Plan that covered the person 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 health care 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 Deductible, Coinsurance, Copayments and any amounts it would have credited to its Deductible in the absence of other health care 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 person 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 or Contract;

   b. determine whether a benefit reserve has been recorded for the covered person; 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 person'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 person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, Benefits are not payable by one Closed Panel Plan, COB 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 health care 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 health care 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. We need this information to determine whether we are the "primary" or "secondary" Benefit payer. The Primary Plan always pays first when you have a Claim. Any Plan that does not contain your state's COB rules will always be primary.

3. When This Plan is Primary

   If you or a family member are covered under another Plan in addition to this one, we will be primary when:

   a. The Claim is for your own health care 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 health care 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 health care 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 health care 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 health care 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 prior Authorization, as required by that Plan, we will not pay the amount of the reduction, because it is not an Allowable Expense.

5. 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 fresh benefit reserve begins for each person 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 person. We need not tell, or get the consent of, any person to do this. Each person 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 persons We have paid or for whom We have paid;

2. insurance companies; or

3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

Article 20. What Else Applies to Your Group Plan? General Provisions

The following general provisions apply to the Group policyholder and all members.

The Group enters into this Plan on behalf of the eligible individuals who enroll in it. If the Group accepts this Plan, those who enroll as Subscribers and Dependents also accept it and are bound by it.

A. The Benefit Plan

1. This Plan, including the *Employee Enrollment/Change Form* and *Schedule of Benefits*, expressing the entire money and amendments or endorsements, make up the entire contract between the parties.

2. Except as specifically provided in this Plan, this Plan will not make Us liable or responsible for any duty or obligation imposed on the obligation that federal or state law impose on the Employer. To the extent that this Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Group will be the administrator of the employee welfare benefit plan and solely must meet any obligations that the law or regulation impose on the administrator, except those We specifically undertake here. To the extent this Plan pays Benefits to treat certain injuries, exclusions to those covered benefits do not apply if they are inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Your Plan will cover illness or bodily injury that result from an act of domestic violence or a medical condition (including both physical and mental health conditions); or for Emergency Medical Services. To the extent this Plan is subject to COBRA, the Group, or its contracted designee, will administer COBRA. The Group must set up and follow all required COBRA procedures that may apply. The Group will indemnify and hold Us harmless if We incur any liability because the Group does not do so.

3. We 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, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with Your care or treatment.

4. We have full discretionary authority to figure eligibility for Benefits or to construe the terms of this Plan. Members that disagree with the Company's determination may pursue any applicable procedures available under the terms of this Benefit Plan and the law.

5. We can enter into any contractual agreements with subcontractors, healthcare providers, or other third parties for this Plan. Any function We are to perform under this Plan may be performed by Us or any of Our subsidiaries, affiliates, subcontractors, or designees.

B. Section 1557 Grievance Procedure

We do not discriminate according to race, color, national origin, sex, age or disability. We have an internal grievance procedure to promptly resolve complaints alleging any action prohibited by Section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination according to 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 Our efforts 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 discriminated against because of race, color, national origin, sex, age or disability, You may file a Grievance. It is against the law for Us 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 and must include Your name and address. In the complaint, state the problem or action alleged to be discriminatory and the remedy or relief You seek.

The Section 1557 Coordinator will investigate the complaint. This investigation may be informal, but it will be thorough. We encourage You to submit evidence related to Your complaint. The Section 1557 Coordinator will keep Our files and records about these Grievances. To the extent possible, the Section 1557 Coordinator will take appropriate steps to keep files and records about Grievances confidential 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 receiving it.

You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within 15 days after You receive the Section 1557 Coordinator's decision. The Section 1557 Grievance Administrator must respond in writing no later than 30 days after receiving it.

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 U.S. Department of Health and Human Services, Office for Civil Rights.

You must file complaints within 180 days of the date of the alleged discrimination.

For complaint forms, go to: **http://www.hhs.gov/ocr/office/file/index.html**.

You can file a complaint electronically through the Office for Civil Rights Complaint Portal at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or 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

We will make appropriate arrangements to ensure that people with disabilities and those with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this process. Arrangements may include 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 make the arrangements.

C. Benefit Plan Changes

Subject to all laws and regulations that apply, We have the right to modify the terms of this Plan with at least 60 days' notice to the Group. No change or waiver of any Plan provision will be effective until Our chief executive officer approves it.

D. Identification Cards and Benefit Plans

We will prepare identification (ID) cards for Subscribers. We will issue a Plan to the Group and print enough copies for Group's Subscribers. At the direction of Group, We will either deliver all materials to the Group for distribution to Subscribers, or We will deliver the materials directly to each Subscriber. The Subscriber's copy of the Plan will serve as the certificate of coverage. Unless otherwise agreed between the Group and Us, the Group alone is responsible for distributing all documents to Subscribers.

E. Benefits to Which Members Are Entitled

1. Our liability is limited to the Benefits specified in this Plan.

2. Your Plan pays for Covered Services specified in this Plan. It will pay only for services and supplies given on and after Your Effective Date by a Provider specified in this Plan and regularly included in Your Provider's charges.

3. Continuity of healthcare services.

    a. When We end a contractual agreement with a Provider, if You have begun a course of treatment with that Provider, We will notify You that We have removed the Provider from the Preferred Care Network. If

you are a continuing care patient, You can continue receiving Covered Services until the earlier of the completion of the course of treatment or 90 days after We notify You that the Provider has left the PPO Provider Network.

b. A continuing care patient is one who is:

(1) Undergoing a course of treatment for a Serious and Complex Condition;

(2) Undergoing a course of institutional or Inpatient care;

(3) Scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care;

(4) Pregnant and undergoing a course of treatment for the pregnancy; or

(5) Terminally ill, which means the medical prognosis is a life expectancy of 6 months or less, and receiving treatment for the terminal illness from the Provider.

c. The provisions of continuity of care do not apply if any one of the following occurs:

(1) The reason for ending a Provider's contractual agreement is a result of documented reasons about quality of care, or the suspension, revocation or applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.

(2) The reason for termination of a Provider's contractual agreement is as a result of fraud.

(3) You voluntarily choose to change Providers.

(4) You move outside of the geographic service area of the Provider or the Preferred Care Network.

(5) Your condition does not meet the requirements to be deemed a Serious and Complex Condition.

F. Notice of Member Eligibility — Employer's Personnel Data

1. The Group must give Us the information We need to enroll Members under this Plan, process terminations, and make changes in family and membership status. Accepting payments for people no longer eligible for coverage will not obligate Us to provide Benefits.

2. All notification of membership or coverage changes must be on forms that We approve and include all information We need to make changes.

3. The Group must notify Our Membership and Billing Department of Members' termination of coverage by completing a cancellation form (or other form of notification We accept). For Subscribers, We must receive the cancellation form by the end of the billing cycle immediately after the billing cycle in which the Subscriber is terminated from employment or eligibility for coverage ends (or any other period described in the *Schedule of Benefits*). For Dependents, We must receive the cancellation form by the end of the billing cycle immediately after the billing cycle in which Dependent is no longer eligible for coverage (or any other period described in the *Schedule of Benefits*). The Group must submit evidence to Our Membership and Billing Department that Members choose to continue coverage after that termination within 3 business days after the Group receives signed continuation forms from the Member. We do not have to refund any premium that the Group or any Member pays if that payment was made to Us because the Group did not notify Us on time that a Member's coverage ended.

4. We will only honor requests for termination of coverage that are submitted after the period provided above prospectively after the date of receipt; the Group must pay all corresponding premiums until the effective date of termination. All requests for termination of coverage — whether timely or not — will be subject to any other terms, conditions, and legal requirements that may apply. Whenever the Group submits a request to Us to end Your coverage or Your Dependents' coverage, We deem that the Group is making a representation that neither You nor Your Dependent made payments toward the cost of Premiums for any coverage period after the date on which the Group wants the coverage to end, and that no information was given or representation was made to You or Your Dependent that would create an expectation that You would continue coverage after that date, except for legally required disclosures about any rights to COBRA or other mandated continuation coverage. If someone has a right to continue coverage under COBRA or any similar mandate, the Group must timely request the person's termination of coverage under the regular process We created for this purpose, and to submit any election from the person for continuation coverage separately.

5. The Group warrants the accuracy of the information it sends to Us and understands that We will rely on this information. If We ask, the Group agrees to supply or allow Us to inspect personnel records to verify eligibility.

6. The Group also agrees to indemnify Us for all expenses We may incur if the Group does not send correct information when required. Indemnification includes Claims payments made on behalf of people who are not eligible for Benefits. Alternatively, We may, at Our sole option, hold the Group responsible for all Premium payments for Members who are not cancelled from coverage on time because the Group did not notify Us of terminations or changes in eligibility.

G. Ending Your Coverage

1. We may choose to rescind coverage or terminate Your coverage if You commit fraud or intentionally misrepresent material fact under the terms of this Plan. Issuing this coverage depends on the representations and statements in the application and enrollment. All representations made are material to issuing this coverage. Any information intentionally omitted from the application or enrollment form, as to any proposed Subscriber or Member, intentionally misrepresents material fact. We may rescind Your coverage retroactively to the Effective date of coverage or terminated within 3 years of Your Effective Date, for fraud or intentional misrepresentation of material fact. We will write to You 60 days before rescinding or terminating coverage under this section. If You are enrolled and are not eligible for coverage, it is fraud or intentional misrepresentation of material fact.

2. Unless Continuation of Coverage is available and selected as provided in this Plan, Your coverage ends as provided below:

    a. Your coverage and Your Dependents' coverage automatically, and without notice, terminates at the end of the billing cycle in which You are no longer eligible.

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

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

    d. When the Subscriber dies, coverage for all surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if premiums have been paid

through that period. However, a surviving Spouse or Dependent may choose to continue coverage as described elsewhere in this Plan.

3. If the Group cancels this Plan or We end it because the appropriate payment was not paid when due or because the Group does not perform any obligation, such cancellation or termination alone will operate to end all Your rights to Benefits under of this Plan as of the Effective Date of such cancellation or termination. The Group must notify You, participants, and Beneficiaries of such cancellation or termination. We do not have to notify You.

4. If the provisions of paragraphs a., b., c. or d. above occur, if You are an Inpatient in a Hospital on the date coverage ends, medical Benefits for Your Admission will end when that Admission ends, or when You reach any Benefit limitations set in this Plan, whichever occurs first.

5. Except as otherwise provided in this Plan, Your Plan does not pay for Covered Services given after the date of cancellation or termination of Your coverage.

6. When no more children or grandchildren are covered under this Plan, We can automatically change the Subscriber's class of coverage.

7. Cancellation or termination will be effective at midnight on the last day of the billing cycle. Billing cycles are from the 1st to the end of the month or from the 15th of the month to the 14th of the next month.

8. When the Group's coverage ends because the plan ceases to exist or COBRA is exhausted, Members may apply for individual coverage to Us or to the Exchange.

H. Filing Claims

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

2. Most Members that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Member. However, if the Member must file a claim to access his Prescription Drug Benefit, the Member must use the *Prescription Drug Claim Form*. Members may obtain the *Prescription Drug Claim Form* by accessing the pharmacy section of Our website, **www.bcbsla.com/pharmacy.** The *Prescription Drug Claim Form*, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The claim form should then be sent to Our Pharmacy Benefit Manager, whose telephone number should be found on the Member's ID card.

I. Applicable Law and Conforming Policy

This Plan is governed and construed according to the laws and regulations of the State of Louisiana except when preempted by federal law. This Plan is not subject to regulation by any other state. If any provision of this Plan conflicts with any law of the State of Louisiana or the United States of America, the Plan will be automatically amended to meet the minimum requirements of the law. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

J. Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.

2. Any and all lawsuits, other than those related to Claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

K. Release of Information

We may ask You or Your Provider to give Us certain information about Your Claim. We will keep that information, records, or copies of records confidential except where in Our discretion We should disclose it.

L. Assignment

1. Your rights and Benefits under this Plan are Yours. You may not assign them in whole or in part to anyone else. We will recognize assignments of Benefits to Hospitals if both this Plan and the Provider are subject to La. R.S. 40:2010. If both are not subject to La. R.S. 40:2010, We will not recognize assignments or attempted assignments of Benefits. Nothing in the written description of health coverage makes the health plan or Us liable to any third party to whom You owe the cost of medical care, treatment, or services.

2. We have the right to pay PPO Providers and Hospitals, and Providers and Hospitals in Our Participating Provider Network directly instead of paying You.

M. Member and Provider Relationship

1. The choice of a Provider is Yours only.

2. We and all Network Providers are independent from each other. We are not agents, representatives, or Employees of each other for any purpose. We do not give Covered Services, but only pay for Covered Services that You receive. We are not liable for any act or omission of any Provider, or for any Claim or demand on account of damages that arise out of, or in any way connected with, any injuries You suffer while receiving care from any Network Provider or in any Network Provider's facilities. We are not responsible if a Provider does not give or refuses to give You Covered Services.

3. Using or not using an adjective such as *Preferred Network*, *Participating*, and *Non-Participating* is not a statement about the Provider's ability.

N. This Benefit Plan and Medicare

1. For Employers with 20 or more active Employees, federal law and regulations require that each active Employee and each active Employee's Spouse — who are both age 65 or older — may choose to have coverage under this Plan or under Medicare.

    a. If those Employees or Spouses choose coverage under this Plan, it will be the primary payor of Benefits. The Medicare program will be the secondary payor.

    b. This Plan will not provide Benefits to supplement Medicare payments for Medicare eligible expenses for those Employees or Spouses where they elect to have the Medicare program as the primary payor.

2. Under federal law, if an active Employee under age 65 or an active Employee's Dependent under age 65 is covered under a Group Benefit Plan of an Employer with 100 or more Employees and also has coverage under Medicare because of Social Security disability, this Plan is the primary payor and Medicare is the secondary payor.

3. If You are younger than 65, are covered under this Plan, and are also covered under Medicare only because You have end-stage renal disease, Medicare will be the primary payor. This Plan will be the secondary

payor, except during the first 30-month period that You are eligible for Medicare Benefits only because of that disease, this Plan will be the primary payor and Medicare the secondary payor.

4. When this Plan is the primary payor, it will pay regular Benefits for Covered Services. When this Plan is the secondary payor, it will pay Benefits based on the Medicare-approved amount or Our Allowable Charge, whichever is less. When Medicare does not require an Allied Provider or Physician to accept the Medicare-approved amount as payment in full, We will base Benefits on the Medicare-approved amount plus Medicare's limiting charge, if it applies, or Our Allowable Charge, whichever is less.

O. Notice

Any notice required under this Plan must be in writing. We will send the Group notices to the Group's address stated in the *Application for Group Coverage*. Notice to Us will be sent to Our address stated in the *Application for Group Coverage*. We will consider any required notice to be delivered to Us when it is deposited in the U.S. Mail, postage prepaid, addressed to You at the address that We have for You in Our records, or to the Group at the address in Our records. We, the Group, or You may change the address in Our records by writing to Us.

P. Job-Related Injury or Illness

The Group must report to the appropriate federal or state governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any federal or state laws and/or related programs. This Benefit Plan excludes Benefits for any services rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes. In the event that We initially extend Benefits and a compensation carrier, employer, governmental agency or program, insurer, or any other entity makes any type of settlement with the Member, with any person entitled to receive settlement when the Member dies, or if the Member's injury or illness is found to be compensable under federal or state workers' compensation laws or programs, the Group or the Member must reimburse Us for Benefits extended or direct the compensation carrier, employer, governmental agency, or program, insurer, or any other entity to make such reimbursement. We will be entitled to such reimbursement even if the settlement does not mention or excludes payment for healthcare expenses.

Q. Subrogation

1. To the extent that Benefits for Covered Services are paid under this Plan, We will be subrogated and will succeed to Your right to recover the amount paid under this Plan against any person, organization or other carrier, even where such carrier provides Benefits directly to You who is its insured. Accepting such Benefits is subrogation. Our right to recover will be subordinate to Your right to be "made whole." We agree that We will pay Our proportionate share of the reasonable attorney fees and costs You paid in pursuing recovery.

2. You will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization or other carrier, even where such carrier pays You directly, to the extent of the Benefits provided or paid under this Plan. Our right to reimbursement will be subordinate to Your right to be "made whole." We agree that We will pay Our proportionate share of the reasonable attorney fees and costs You paid in pursuing recovery.

3. You will take such action, give such information and assistance, and execute such papers as We may require to help enforce Our rights, and will take no action prejudicing the rights and interest of Us under this Plan. We and Our designees have the right to obtain and review Your medical and billing records, if We decide that those records would help pursue Our right of subrogation or reimbursement. Nothing in this

provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Plan.

4. You must notify Us of any Accidental Injury.

R. Right of Recovery

Whenever We have paid for more than the maximum Benefits available for Covered Services under this Plan or more than the Allowable Charge, or whenever payment has been made in error by Us for non-Covered Services, We can recover that payment from You or the Provider, if appropriate. As an alternative, We can deduct from any pending Claim any amounts that You or Provider owes Us.

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

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

The United States will have the right to collect from Us the reasonable cost of healthcare services incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that the retiree or Dependent would be eligible to receive reimbursement or indemnification from Us if the retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible and Coinsurance amount.

T. Liability of Plan Affiliates

On behalf of itself and its participants, the Group expressly acknowledges its understanding that this Plan is a contract only between the Group and Us, that We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association — an association of independent Blue Cross and Blue Shield Plans — the *Association* permitting Us to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that We are not contracting as the agent of the Association. The Group, on behalf of itself and its participants, also acknowledges and agrees that it has not entered into this Plan based on representations by anyone other than Us and that no person, entity, or organization other than Us is accountable or liable to the Group for any of Our obligations to the Group created under this Plan. This paragraph does not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this agreement.

U. Out-of-Area Services

We have a variety of relationships with other Blue Cross or Blue Shield Plans and their Licensed Controlled Affiliates (*Licensees*). Generally, these relationships are called *Inter-Plan Arrangements*. These Inter-Plan Arrangements work based on rules and procedures that the Blue Cross and Blue Shield Association issues. Whenever You receive healthcare services outside Our geographic area, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of Our service area, You will receive it from one of two kinds of Providers: either Participating or Non-Participating Providers. Most *Participating Providers* contract with the local Blue Cross or Blue Shield Licensee in that geographic area (*Host Blue*). *Non-Participating Providers* do not contract with the Host Blue. We explain how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types may be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits when paid as medical Benefits, and those Prescription Drug Benefits or vision care Benefits that a third party may administer.

1. BlueCard® Program

   Under the BlueCard® Program, when You receive Covered Services in the geographic area that a Host Blue serves, We will do what We agreed to do in the plan. But the Host Blue must contract with and generally handle all interactions with its Participating Providers.

   When You receive Covered Services outside Our service area and the Claim is processed through the BlueCard® Program, the amount You pay for the Covered Services is calculated based on one of the following as determined by Us:

   - the billed charges for Your Covered Services; or
   - the negotiated price that the Host Blue makes available to Us; or
   - an amount determined by applicable law.

   Often, this *negotiated price* will be a simple discount that reflects an actual price that the Host Blue pays Your Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your Provider or Provider group that may include types of settlements, incentive payments, and 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 Providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of Claims, as noted above. Those adjustments will not affect the price We used for Your Claim because We will not apply them after a Claim has already been paid.

2. Special Case: Value-Based Programs

   a. BlueCard® Program

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

   b. Negotiated (non- BlueCard® Program) Arrangements

      If We have a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on Your behalf, We will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as for the BlueCard® Program.

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

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

4. Non-Participating Providers Outside Our Service Area

   a. Member Liability Calculation

      When You go outside of Our service area to Non-Participating Providers for Covered Services, We will normally base the amount You pay on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements that state law requires. In these situations, You may have to pay the difference between the amount that the Non-Participating Provider bills and how much We pay for the Covered Services as stated in this paragraph. Federal or state law may govern payments for Non-Network Emergency Medical Services.

   b. Exceptions

      In certain situations, We may use other payment methods, such as billed charges for Covered Services, the payment, to figure 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 from Non-Participating Providers. In these situations, You may have to pay the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as stated in Your Plan.

5. Blue Cross Blue Shield Global® Core

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

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

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

   or call collect

   1.804.673.1177

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

   a. Inpatient Services

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

But, if You paid in full when You received services, You must submit a Claim to be reimbursed. You must contact Us for Authorization for non-Emergency Inpatient services, as explained in Article 16: *Care Management*.

b. Outpatient Services

If You go to Physicians, Urgent Care Centers and other Outpatient Providers outside the BlueCard® service area, typically You must pay in full when You receive service. To be reimbursed, You must submit a Claim.

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 be reimbursed. For institutional and professional Claims, fill out *a Blue Cross Blue Shield Global® Core Claim Form.* Send the form with the Provider's itemized bills to the Blue Cross Blue Shield Global® Core service center at the address on the form.

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

For help submitting Your Claim, call:

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

or call collect:

1-804-673-1177

V. HIPAA Certificates of Creditable Coverage

We will issue a certificate of Creditable Coverage or similar document to You, if You ask within 24 months after coverage under this Plan ends.

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

The Medicare Modernization Act (MMA) requires groups whose policies include Prescription Drug coverage to notify Medicare-eligible Members whether their Prescription Drug coverage is creditable, which is defined to mean that the coverage is expected to pay on average as much as the standard Medicare Part D Prescription Drug coverage. The types of coverage required to provide the notices are those listed at 42 CFR 423.56(b) and includes, but is not limited to, group health plans (i.e., the Plan Sponsor), individual health insurance coverage, and Medicare supplement plans. For these groups, there are two disclosure requirements:

1. The first disclosure requirement is to provide a written disclosure notice to all Medicare-eligible Members annually who are covered under its Prescription Drug plan, prior to October 15th each year and at various times as stated in the regulations, including to a Medicare-eligible Member when they join the Plan. This disclosure must be provided to Medicare-eligible active working Members and their Dependents, Medicare-eligible COBRA Members and their Dependents, Medicare-eligible disabled Members covered under its Prescription Drug plan and any Retirees and their Dependents. The MMA imposes a late enrollment penalty on Members who do not maintain creditable coverage for a period of 63 days or longer following their initial

enrollment period for the Medicare Prescription Drug Benefit. Accordingly, this information is essential to a Member's decision whether to enroll in a Medicare Part D Prescription Drug plan.

Groups are responsible for sending the required notices. As a service to the Group and based upon enrollment data provided to Us by the Group, We shall provide, without charge, Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to Medicare-eligible Member who have Prescription Drug coverage under this Benefit Plan at the following times, or as otherwise directed by law:

a. before the Medicare Part D Annual Coordinated Election Period;

b. before an individual's Initial Enrollment Period (IEP) for Medicare Part D (age-in);

c. prior to the Effective Date of coverage for new Medicare-eligible Employees that join this Benefit Plan;

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

e. when a Medicare Beneficiary asks for it.

2. The second disclosure requirement is for groups to complete the Online Disclosure to CMS Form to report the Creditable Coverage status of their Prescription Drug Plan. The Disclosure should be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a Prescription Drug Plan, or within 30 days after any change in creditable coverage status. This requirement does not pertain to the Medicare beneficiaries for whom groups are receiving the Retiree Drug Subsidy (RDS).

   Groups are responsible for the submission of the *Online Disclosure to CMS Form.*

X. Continued Coverage When Employee Not Actively Working

As stated in the *Schedule of Eligibility*, to be entitled to coverage under this Plan, Employees must be actively working for their Employer or Group. Each of the following provisions are exceptions to that requirement. The following provisions are independent; only one need apply for Subscribers and their Dependents to be entitled to continued coverage under this Plan. If claims are paid when Employee was not Eligible for coverage, Company may recover the claims payments.

1. We will continue coverage for You during any leave of absence the Group is required to provide by federal or state law, including the Family and Medical Leave Act of 1993 (FMLA), the Americans with Disabilities Act or Pregnancy Discrimination Act, and any amendments or successor provisions, as long as all other eligibility criteria under the laws continues to be met. If Your coverage ends during a leave under the FMLA, when You return to active full-time employment, You are entitled to re-enroll for coverage so long as the Group keeps its coverage with Us. If You are not restored to active full-time employment by the end of the leave of absence period, You will no longer be eligible and coverage for You 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 *Ending Your Coverage*. You and Your Dependents may have the right to continue coverage after that under Article 18: *Your Rights to Continue Coverage*.

2. When You have been granted a documented, approved leave of absence by the Employer Group, and the leave of absence is not due to Your health, We will keep coverage for You and any Covered Dependents for

no longer than 90 days. Premiums must be paid and You must remain a bona fide Employee of Group during the approved leave period. If We ask, the Group will give Us proof of the documented leave. If the Group ends Your employment, You will no longer be eligible and coverage for You and any Dependents will end as described in *Ending Your Coverage*. You and Your Dependents may have the right to continue coverage after that under Article 18: *Your Rights to Continue Coverage*.

Y. Our Right to Offer Premium Incentives

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

1. Encouraging Members and/or policyholders to participate in quality programs;

2. Ensuring Members and/or policyholders are better able to afford benefits packages;

3. Reducing and alleviating social determinants of health;

4. Reducing transition costs for Members and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;

5. Rewarding Members and/or policyholders for choosing lower cost, quality healthcare providers;

6. Rewarding Members and/or policyholders for selecting lower cost, quality healthcare goods and products;

7. Rewarding Members and/or policyholders for utilizing digital and other paperless forms of communication of information, including but not limited to plan documents and materials; and

8. Reducing enrollment, technology, or administration costs of Members and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

Article 21. How Can You File a Complaint, Grievance, or Appeal?

We want to know when a Member is dissatisfied about the care or services received from Blue Cross and Blue Shield of Louisiana or one of Our Providers. If a Member wants to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

A Member may be dissatisfied about decisions We make regarding Covered Services. We consider a written Appeal as the Member's request to change an Adverse Benefit Determination made by the Company.

Your Appeal rights are outlined below, after the Complaint and Grievance Procedures. In addition to the medical Appeals rights, the Member's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of Our coverage decision when they concern Medical Necessity determinations.

We have expedited Appeal processes for situations where the time frame of the standard medical Appeals would seriously jeopardize the life or health of a Covered Person, or would jeopardize the covered person's ability to regain maximum function.

A. Complaint, Grievance, and Informal Reconsideration Procedures

A quality of service concern addresses Our services, access, availability or attitude and those of Our Network Providers. A quality of care concern addresses the appropriateness of care given to a Member.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Members may call Customer Service to register a Complaint. We will attempt to resolve a Member's Complaint at the time of their call.

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

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Member does not feel his Complaint was adequately resolved or he wishes to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, the Member may call Our customer service department.

Send written Grievances to:

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

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

3. Informal Reconsideration

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

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

B. Standard Appeal Procedures

Multiple requests to Appeal the same Claim, service, issue, or date of service will not be considered, at any level of review.

We offer the Member two (2) levels of Appeal. If a Member is an ERISA Member, the Member is required to complete the first level of Appeal prior to instituting any civil action under ERISA section 502(a). The second level of Appeal is voluntary. Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Member's decision whether or not to submit to this voluntary level of review will have no effect on the Member's rights to any other Benefits under the plan. No fees or costs will be imposed on the Member.

The Member should contact his Employer, Plan Administrator, Plan Sponsor, or Our Customer Service Department at 1-800-599-2583 or 1-225-291-5370 if the Member is unsure whether ERISA is applicable.

The Member may also call Our customer service department if they have questions or need assistance putting their Appeal in writing.

C. Standard Appeal Process

We will determine if a Member's Appeal is an administrative Appeal or a medical Appeal. The Appeals procedure has two (2) levels, including review by a committee at the second level on an administrative Appeal and a review by an external Independent Review Organization (IRO) on a medical Appeal.

The Member is encouraged to provide Us with all available information to help Us completely evaluate the Appeal such as written comments, documents, records, and other information relating to the Adverse Benefit Determination. We will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his Adverse Benefit Determination.

The Member has the right to appoint an authorized representative to represent him in his Appeals. An authorized representative is a person to whom the Member has given written consent to represent him in an internal or external review of an Adverse Benefit Determination. The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing.

1. Administrative Appeals

   Administrative Appeals involve contractual issues, Rescissions 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.

   Administrative Appeals should be submitted in writing to:

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

   a. First Level Administrative Appeals

      If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination for first level administrative Appeals. Requests submitted to Us after one hundred eighty (180) days of Our initial Adverse Benefit Determination will not be considered.

      We will investigate the Member's concerns. If the administrative Appeal is overturned, We will reprocess the Member's Claim, if any. If the administrative Appeal is upheld, We will inform the Member of the right to begin the second level Appeal process.

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

b. Second Level Administrative Appeals

After review of Our first level Appeal decision, If a Member is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of Our first level Appeal decision. Requests submitted to Us after sixty (60) days of Our first level Appeal decision will not be considered.

A Member Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level Appeals. The Committee's decision is final and binding.

The Committee's decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within five (5) days of the Committee meeting.

Second Level Administrative Appeals are not applicable to a Rescission of Coverage, which follows the External Appeals track.

2. Medical Appeals

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

We offer the Member two (2) standard levels of medical Appeals, including an internal review of the initial Adverse Benefit Determination, then an external review.

Medical Appeals should be sent to:

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

a. Internal Medical Appeals

If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of Our initial Adverse Benefit Determination for internal medical Appeals. Requests submitted to Us after one hundred eighty (180) days of Our initial Adverse Benefit Determination will not be considered.

A Physician or other healthcare professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, We will reprocess the Member's Claim, if any. If the internal medical Appeal is upheld, We will inform the Member of their right to begin the External Appeal process if the Adverse Benefit Determination meets the criteria.

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

b. External Medical Appeal and Rescission of Coverage

For medical Appeals and Rescission of Coverage, the second level will be handled by an external Independent Review Organization (IRO) that is not affiliated with Us and randomly assigned by the Louisiana Department of Insurance.

A Member must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization.

If the Member still disagrees with the internal medical Appeal decision or Rescission of Coverage, a written request for an External Appeal must be submitted within four (4) months of receipt of the internal medical Appeal decision or Rescission of Coverage.

Requests submitted to Us after four (4) months of receipt of the internal medical Appeal decision or Rescission of Coverage will not be considered. You are required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. Appeals submitted by Your Provider will not be accepted without this form completed with Your signature.

We will provide the IRO all pertinent information necessary to conduct the Appeal. The external review will be completed within forty-five (45) days of Our receipt of the External Appeal. The IRO will notify the Member, his authorized representative, or a Provider authorized to act on the Member's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Member and Us for purposes of determining coverage under a health plan. This Appeals process shall constitute your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary or Investigational, except to the extent that other remedies are available under State or Federal law.

D. Expedited Appeals

The expedited 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 Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard Medical Appeal decision.

An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare service for a Member currently 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 Member, his authorized representative, or a Provider authorized to act on the Member's behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

Blue Cross and Blue Shield of Louisiana
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 Us and the Member or the Provider acting on behalf of the Member, the Appeal may be elevated to an Expedited External Appeal.

   If an Expedited internal medical Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process and timeframe.

2. Expedited External Medical Appeal

   An Expedited External Appeal is a request for immediate review, by an Independent Review Organization (IRO). The request may be simultaneously filed with a request for an internal Expedited Appeal, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for Expedited External Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

For all Medical Appeals, Office of Consumer Advocacy of the Department of Insurance is available to assist with the appeals process. You may contact the Commissioner of Insurance directly for assistance at:

Commissioner of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214

1-225-342-5900 or 1-800-259-5300

Article 22. Your ERISA Rights

To the extent this is an ERISA plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For this provision, the Group is the Plan Administrator and will be subject to the provisions stated below.

According to ERISA, You are entitled to:

A. You Can Receive Information About the Plan and Benefits

1. You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents that govern the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that the Plan filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. If You write to the Plan Administrator, You may obtain copies of documents about how the Plan operates, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator charges a reasonable cost for the copies.

3. You may receive a summary of the Plan's annual financial report. By law, the Plan Administrator must give You a copy of this summary annual report.

B. You May Continue Group Health Plan Coverage

You may continue healthcare coverage for Yourself, Your Spouse, or Your Dependents, if You lose coverage as a result of a qualifying event. But You or Your Dependents may have to pay for that coverage. You may also review this document and the Summary Plan Description governing the plan on the rules about Your COBRA continuation of coverage rights.

C. Plan Fiduciaries Must Act Prudently

In addition to creating Your rights, ERISA imposes duties on the people who operate the Employee Benefit Plan. They are called *fiduciaries.* Fiduciaries have a duty to operate the Plan prudently and in the interest of You and other Beneficiaries. No one — including Your Employer, union or any other person — may fire You or otherwise discriminate against You in any way to stop You from obtaining a Plan Benefit or exercising Your rights under ERISA.

D. You Can Enforce Your Rights

If We deny or ignore Your Claim, in whole or in part, You have a right to know why this was done, to obtain copies of documents about the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, You can take steps to enforce the above rights. You must exhaust all Claims and Appeal available procedures before filing any suit.

For instance, if You ask for a copy of Plan documents or the latest annual report and You do not receive them within 30 days, You may file suit in federal court. In that a case, the court may require the Plan Administrator to provide the materials and pay You up to $110.00 a day until You receive the materials, unless We did not send the materials because of reasons beyond the Plan Administrator's control.

If We ignore or deny Your Claim, in whole or in part, You may file suit in a state or federal court.

If You disagree with the Plan's decision or lack of a decision about the qualified status of a domestic relations order or a medical child support order, You may file suit in federal court.

If the Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek help from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it decides that Your claim is frivolous.

E. Get Help with Your Questions

If You have any questions about Your plan, contact the Plan Administrator.

If You have any questions about this statement or Your rights under ERISA, or if You need help getting documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

For certain publications about Your rights and responsibilities under ERISA, call the publications hotline of the Employee Benefits Security Administration.

Article 23. How to Make Plan Changes and File Claims

We continue to update online access for You. You may now be able to perform many functions described below, without contacting Customer Service. Go to www.bcbsla.com for these services.

For all of the forms mentioned in this section, contact Your Employer's personnel office, one of Our local service offices, or Our home office. Our local service offices are in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe, and Shreveport.

To submit documentation to Us, send it to Our home office at:

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

or to:

5525 Reitz Avenue
Baton Rouge, LA 70809

If You have any questions about any information in this section, contact Your Employer or call Customer Service at the number on Your ID card.

A. How to Change Family Members on Your Plan

The *Schedule of Eligibility* tells You when You may add other family members to Your Plan.

You must make all policy changes through the agent or through Us. We must receive a *Employee Enrollment / Change Form* to enroll family members who were not on Your original *Application for Group Coverage*. Fill out the *Employee Enrollment / Change Form* to add newborn children, newborn adopted children, a Spouse, or other Dependents.

Because You are covered under a Group insurance plan, it is extremely important that You follow the timing rules in the *Schedule of Eligibility*. **If You do not complete and return a required *Employee Enrollment / Change Form* within the timeframes stated in the *Schedule of Eligibility*, Your insurance may not include other family members.** Completing and returning a *Employee Enrollment / Change Form* is especially important when You no longer have any eligible Dependents.

B. How to File Claims for Benefits

We most Providers have entered into agreements that eliminate the need for You to personally file a Claim for Benefits. Preferred or Participating Providers will file Claims for You either by mail or electronically.

In certain situations, the Provider may request You to file the Claim. If Your Provider asks You to file directly with Us, the following information will help You correctly fill out the Claim form.

Your ID card shows the way the name of the Subscriber (Member of the Group) appears on Our records. (If You have Dependent coverage, the names are recorded as shown in the enrollment information We received.) The ID card also lists Your Plan number (ID #). This number identifies Your membership records and should be given to Us each time a Claim is filed.

To help in promptly handling Your Claims, be sure that:

- an appropriate Claim form is used
- the Plan number (ID #) shown on the form is the same as the number on Your ID card
- the patient‘s date of birth is listed
- the patient‘s relationship to the Subscriber is correct
- all charges are itemized on a statement from the Provider
- the itemized statement from the Provider contains the Provider’s name, address, and tax ID number and is attached to the Claim form
- the date of service (date of Admission to a Hospital or other Provider) or date of treatment is correct
- the Provider includes a diagnosis and procedure code for each service or treatment (the diagnosis code pointers must be consistent with the Claim form)
- both You and Your Provider complete and sign the Claim.

C. Prescription Drug Claims

Most Members with Prescription Drug coverage will not have to file Claims for Prescription Drug Benefits because this is done automatically if You show Your ID card to a Participating Pharmacist. But, if You must file a Claim for Your Prescription Drug Benefit, You must use the *Prescription* Drug *Claim Form*.

To get a *Prescription Drug Claim Form,* go to www.bcbsla.com/pharmacy. The *Prescription Drug Claim Form* — or an attachment We accept — may need the dispensing pharmacist's signature. The Claim form should then be sent to Our Pharmacy Benefit Manager, whose number is on Your ID card.

We will pay Benefits to You based on the Allowable Charge for the Prescription Drug.

D. Other Medical Claims

When You receive other medical services (clinics, Provider offices, etc.) You should ask if the Provider is a Preferred or Participating Provider. If so, this Provider will file Your Claim with Us. In some situations, the Providers may ask You to pay them and ask You to file. If this occurs, You must be sure the Claim form is complete before sending it to Us.

If You file the Claim, it must have the itemized charges for each procedure or service. You may not use statements, canceled checks, payment receipts, and balance forward bills.

Itemized bills submitted with Claim forms must include the following:

- full name of patient,
- dates of service,
- description of and procedure code for service,
- diagnosis code,
- charge for service, and
  name and address of the Provider.

E. Claims for Nursing Services

You must have a receipt for nursing services from each nurse. The receipt must show the patient's name and the number of days that the receipt covers. Each receipt must also be signed by the nurse with the initials RN or LPN and registry number. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary may also need to be filed with the receipts for nursing services.

F. Durable Medical Equipment (DME) Claims

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

G. Mental Health and Substance Use Disorder Claims

For help filing a Claim for Mental Health or substance use disorders, call Customer Service at the number on Your ID card.

H. Claims Questions

For information about Claims, go to www.bcbsla.com. You can also call Customer Service at the number on Your ID card; go to any local service office in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport; or write to Us at:

Blue Cross and Blue Shield of Louisiana
5525 Reitz Avenue
P. O. Box 98029
Baton Rouge, LA 70898-9029

If You call about a Claim, We can help You better if You have the information at hand, particularly the Plan number, patient's name, and date of service.

Remember, ALWAYS refer to Your contract number in all correspondence and recheck the number against the contract number on their ID card to be sure it is correct.

Article 24. What Applies to Policyholders Only?

In addition to the general provisions for the Group Policyholder and Members, the following general provisions also apply to the Group Policyholder.

A. Due Date for Group's Premium Payments

1. Before You can be covered, the Group Policyholder must pay the premiums when they are due. Premiums are due beginning with the Effective Date of this Plan and on the same date each month after that. This is the *premium due date*.

2. The Group Policyholder must pay the premiums. Premiums may not be paid by third parties, including Hospitals, Pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. We will not accept premium payments by third parties unless the law requires Us to do so. Do not rely on the fact that We have accepted premiums from an unrelated third party as an indication that We will do so in the future.

3. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean We will accept late premiums in the future. You may not rely on the fact that We may have previously accepted a late premium as indication that We will do so in the future.

4. Premiums must be paid in U.S. dollars. We will assess the Group Policyholder a $25.00 NSF fee if the bank returns a premium check because of insufficient funds. If the bank returns multiple checks, We may refuse to reinstate coverage.

B. Change in Premium Amount

1. Premiums for this Plan may increase after the Group's first 12 months of coverage and every 6 months thereafter, except when premiums may increase more frequently as described in the next paragraph. Except as provided in the next paragraph, We will give Group 45 days' written notice of any change in premium rates and 90 days' written notice for Employer groups with more than 100 enrolled Employees. We will send notice to the Group's latest address shown in Our records. Any increase in premium is effective on the date specified in the rate change notice. If the Group continues to pay premiums, that means the Group accepts the change.

2. At any time during the life of the Plan, We can increase the premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered when We figured rates. This risk includes the right to increase the premium amount because of:

   a. the addition of a newly Covered Person;
   b. the addition of a newly covered entity;
   c. a change in age or geographic location of any individual insured or Policyholder;
   d. or a change in the policy Benefit level from that which was in force at the time of the last rate determination.

   An increase in premium will become effective on the next billing date after the effective date of the change to the risk. If the Group continues to pay premiums, that means the Group accepts the change.

C. Group to Distribute and Account for Premium Rebate

If federal or state law requires Us to rebate part of an annual premium payment, We will pay the Group Policyholder the total rebate that applies to the Plan, and Group, on Our behalf, will distribute a pro-rata share of the rebate to each Subscriber (including Employees, retirees, and elected officials as covered on the Group's Benefit Plan) based on their contribution to the premium rebated. The Group will notify appropriate federal and state tax agencies and will ensure that each payment to Subscribers will include appropriate federal and state documentation, for example Form 1099. The Group must develop and keep records and documentation showing accurate distribution of any rebate and will provide those records to Us if We ask for them.

These records must include the amount of:

1. the premium each Subscriber paid;
2. the premium the Group paid;
3. the rebate given to each Subscriber;
4. the rebate kept by the Group; and
5. any unclaimed rebate and how and when it will be or was distributed.

The Group will ensure that any unclaimed rebate amounts will be reported according to the unclaimed property laws of the Subscriber's state of domicile. The Group will indemnify Us if We suffer any fines, penalties, or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this Section of the Group Health Benefit Plan.

D. The Group's Right to Cancel the Plan

1. This Plan is guaranteed renewable at the option of the Group. By paying premiums on time, the Group shows its desire to continue coverage.

2. The Group may cancel this policy for any reason.

3. To cancel the policy, **the Group must write to Us of its intent to cancel. The Group may not verbally cancel this coverage. The Group's written notice of cancellation must be given to us before or on the effective date of the cancellation and must be accompanied by return of the Plan.** If Group's written notice to Us of its intent to cancel is not accompanied by the surrendered policy, Group's cancellation notice to Us will be deemed to include Group's declaration that the Group made a good faith attempt to find its policy and the policy is not returned because it has been lost or destroyed.

E. Our Right to End the Plan Because Premiums Were Not Paid

1. Before coverage is given, Premiums must be paid. We consider the Group to be delinquent if premiums are not paid on the due date.

2. We offer a 30-day grace period (*delinquency period*) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect during the grace period according to the policy. If We do not receive the premium during the grace period, We will mail a delinquency or termination notice to the Group's address of record. We may automatically terminate the policy without further notice to the Group if We do not receive Group's premium at Our home office within 30 days of the due date (during the grace period). If We terminate this Benefit Plan for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid. We will not be liable for any Benefits for services rendered after the last date through which premiums have been paid.

F. Our Right to End the Plan for Reasons Other than Nonpayment of Premium

1. We may end this Plan with sixty (60) days advance written notice to group, providing the reason for termination, if any one of the following occurs:

   a. Group commits fraud or makes an intentional misrepresentation.

   b. Group fails to comply with a material plan provision, including, but not limited to, provisions relating to eligibility, Employer contributions or group participation rules. If the sole reason for termination is that Group's participation falls to less than one (1) Employee (only the owner is left on the policy), termination of Group coverage will be effective on the Group's next anniversary date. Otherwise, termination for a reason addressed in this paragraph will be effective after Group receives sixty (60) days written notice.

   c. In the case of network plans, there is no longer any enrollee under the Group Benefit plan that lives, resides, or works in the service area of the Company or in the area for which the Company is authorized to do business.

   d. Group's coverage is provided through a bona fide association and the Employer's membership in the association ends.

   e. Company ceases to offer this product or coverage in the market (ninety (90) days advance written notice will be given to the Group, participants, and Beneficiaries).

   Advance written notice will be given to the Group in accordance with the timeframe required by law.

G. Proxy Votes

A majority vote of its Policyholders elects the Board of Directors of the Plan and determines certain significant corporate transactions, unless the law or the Plan's Articles of Incorporation or Bylaws require a different vote. By means of the *Application for Group Coverage,* a Policyholder designates the members of the Board of Directors of the Plan as a proxy to vote on these important matters.

Payment of each premium extends the proxy's effectiveness unless revoked by the Policyholder. This proxy may be revoked if the Policyholder notifies in writing. This revocation may be in any form of writing either revoking the proxy or designating a different proxy and must be sent to the Plan at:

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

Instead of giving proxy on the *Application for Group Coverage*, the Policyholder may designate any other Policyholder as proxy by any form of writing which includes the Policyholder's name and policy number, sent to the Plan as shown above. Notice of meetings to the proxy is notice to the Policyholders' giving their proxies. Also, the Plan's annual meeting is held in the month of February with notice of the date of that meeting being given as required by law and the articles and bylaws of the Louisiana Health and Service Indemnity Company. However, We will send other notice of meetings to any Policyholder or proxy when the Policyholder writes to Our secretary asking to be notified.

H. Out-of-Area Services

For more explanation of these Inter-Plan Arrangements and the BlueCard® Program, see the Out-of-Area Services section in the Article 20: *What Else Applies to Your Group Plan? General Provisions*.

We have a variety of relationships with other Blue Cross or Blue Shield Licensees generally called *Inter-Plan Arrangements*. These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross and Blue Shield Association (*Association*). Whenever You go outside Our geographic area for Covered Services, We may process the Claim through an Inter-Plan Arrangement, and the other Blue Cross or Blue Shield Licensee (*Host Blue*) will contract for and handle all interactions with its Participating Providers. The financial terms of the BlueCard® Program are described generally below.

1. BlueCard® Program Liability Calculation Method Per Claim

   Unless subject to a fixed dollar Copayment, We will figure how much You owe for Covered Services based on the Participating Provider's billed charges for Covered Services or the negotiated price made available to Us by the Host Blue, whichever is less.

   Host Blues figure a negotiated price, which is reflected in the terms of each Host Blue's health care Provider contracts. The negotiated price made available to Us by the Host Blue may be represented by one of the following:

   a. An actual price. An actual price is a negotiated rate of payment in effect when a Claim is processed without any other increases or decreases, or

   b. An estimated price. An estimated price is a negotiated rate of payment in effect when a Claim is processed reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

   c. An average price. An average price is a percentage of billed charges for Covered Services in effect when a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Providers or a similar classification of its Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

      Host Blues decides whether to use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (that is, prospective adjustment may mean that a current price reflects additional amounts or credits for Claims already paid to Providers or anticipated to be paid to or refunds

received or anticipated to be received from Providers). However, the BlueCard® Program requires that the amount paid by the Member is a final price; no future price adjustment will increase or decrease the pricing of past Claims. The method of Claims payment by Host Blues is taken into account by Us in determining Group's/Policyholder's premiums.

2. Special Cases: Value-Based Programs

   We have included a factor for bulk distributions from Host Blues in Group's premium for Value-Based Programs when it applies under this Plan.

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

   In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If it applies, We will include that amount as part of the Claim charge that will be used to figure how much You owe, and will use it in figuring Group's premium.

4. Non-Participating Providers Outside Our Service Area

   For an explanation on how We figure liability for the Claims from Non-Participating Providers outside Our service area, see the Out-of-Area Services section in the Article 20: *What Else Applies to Your Group Plan? General Provisions.*

I. Health Insurance Portability and Accountability Act (Privacy and Security)

1. For this provision, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

   a. Group Health Plan as defined at 45 CFR Part 160, Sec. 160.103.

   b. Protected Health Information (PHI) as defined at 45 CFR Part 164, Sec. 164.501.

   c. Summary Health Information as defined at 45 CFR Part 164, Sec. 164.504(a).

2. Disclosing Information to the Group

   a. Sharing Summary Health Information with the Group:

      We may disclose Summary Health Information to the Group if the Group requests Summary Health Information to obtain premium bids from health insurers, HMOs or other third-party payers under the Group Health Plan; or modify, amend or terminate the Group Health Plan.

   b. Sharing PHI with the Group:

      We may disclose PHI to the Group to enable the Group to carry out plan administration functions only when We receive a certification from the Group that:

      (1) its plan documents include all requirements stated in 45 CFR Part 164, Sec. 164.504(f) (2) (i), (ii) and (iii);

      (2) it has notified those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520 (B) (1) (iii) (C); and

      (3) that such PHI will not be used for employment-related actions or decisions or with any other Benefits or Employee Benefits plan of the Group.

c. The Group agrees to abide by Our acknowledgement and Authorization policies about exchanging PHI in an electronic format. For example, if We provide data to the Group on a compact disc, We may require acknowledgement that the Group received the data and the name of the Group representative who received it.

J. Compliance with U.S. Laws for Economic Sanctions

The Group agrees to comply fully with all economic sanctions and export control laws and regulations that apply, including those regulations that the U.S. Treasury Department's Office of Foreign Assets Control (OFAC) maintains.

The Group understands that We do not authorize extending coverage to anyone to whom the provision of that coverage would receive coverage under this or Our other Policies, including Subscribers and their Dependents, against all relevant U.S. Government lists of people subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to cover anyone.

The Group agrees that when it accepts coverage, that represents to Us that the Group complied with all laws and regulations that apply and that coverage is not being provided to any denied person.

Any extension of coverage that does not comply with what is stated above will be cause to immediately end this Benefit Plan and deny Benefits for any Claims made under that coverage, and will entitle Us to indemnification from the Group for any cost, loss, damage, liability, or expense We incurred as a result. This provision remains after this Plan ends or is cancelled.

K. 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 or any other policy of insurance. Policyholder is never under any obligation to accept Value-Added Services, and Company may cease offering and paying for Value-Added Services at any time.

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)