



Group Care PPO

SMALL BUSINESS
GROUP HEALTH BENEFIT PLAN



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

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

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

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

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

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

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

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



Thank you for choosing us!

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

My best to you,

A handwritten signature in black ink, appearing to read "Steven Udvarhelyi". The signature is fluid and cursive.

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

SMALL BUSINESS GROUP CARE PPO

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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, DEDUCTIBLES AMOUNTS, COINSURANCES AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT NETWORK AND NON-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT WWW.BCBSLA.COM OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON THE ID CARD.

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

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

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

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

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

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

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

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

Important information regarding this Plan will be sent to the mailing address provided for a Plan Participant on their Employee Enrollment / Employee Change Form. **Plan Participants are responsible for keeping Us 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 the 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 the formulary is available to You in several ways. Most Plan Participants receive information from Us by accessing the pharmacy section of Our website, www.bcbsla.com/pharmacy.

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

OPEN PRESCRIPTION DRUG FORMULARY

With an open formulary, the Claims Administrator 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 Benefit Plan.

CLOSED PRESCRIPTION DRUG FORMULARY

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

For Prescription Drugs that are not included in 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 health coverage regardless of whether the drug has been removed from the 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.

**GROUP CARE PPO
GROUP HEALTH BENEFIT PLAN**

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Article 1. UNDERSTANDING THE BASICS OF YOUR COVERAGE

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

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

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

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

FACTS ABOUT THIS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

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

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

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

OUR PREFERRED PROVIDER NETWORK

Plan Participants choose which Providers will give care. This choice will determine how much We pay and how much the Plan Participant pays 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 the Blue Cross and Blue Shield of Louisiana Preferred Care PPO Network and render services to Plan Participants. These Providers are called Preferred Providers. Oral Surgery Benefits are also available when given by Providers in the United Concordia Dental Advantage Plus Network or in Blue Cross and Blue Shield of Louisiana's dental Network.

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

A Provider's status may change from time to time. Always verify the Provider's Network status before receiving services.

A Provider may have a contract with Us to provide services at one location, but not at another location. Check the Provider directory to verify that the services are In-Network at the location where the Plan Participant seeks care.

A Providers in the 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), We will pay for those services at the Non-Network Benefit level.

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

RECEIVING CARE OUTSIDE THE PREFERRED CARE PPO NETWORK

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

We pay a lower level of Benefits when the Plan Participant goes to Providers outside the Preferred Care PPO Network. We may base Benefits on a lower Allowable Charge. Care obtained outside Our Network means the Plan Participant pays higher costs and pays higher Copayments, Deductible Amounts, and/or Coinsurances than if the Plan Participant had stayed in the Network. **These additional costs may be significant.** Also, We only pay part of those charges, and it is the Plan Participant's responsibility to pay the remainder. To the extent required by applicable law, cost sharing for Emergency Medical Services will be at the Network level even if the Hospital is not in the Network.

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

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

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

In the United States:

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

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

Outside the United States:

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

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 the ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.

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

USING A PRIMARY CARE PHYSICIAN (PCP)

This Benefit Plan is sold with or without an office visit Copayment. The Schedule of Benefits will state whether a Copayment applies. If a Copayment for Physician office visits is shown on the Schedule of Benefits, this direct access plan allows the Plan Participant to receive care from a Primary Care Physician (PCP) or from a Specialist. No PCP referral is required prior to accessing care directly from a Specialist in the Preferred Care PPO Network.

Plan Participants pay the lowest Physician Copayment when obtaining care from a PCP. PCPs are family practitioners, general practitioners, internists, geriatricians, or pediatricians. Each member of the family may use a different PCP. PCPs may coordinate healthcare needs from consultation to hospitalization, direct a Plan Participant to an appropriate Provider when necessary, and assist in obtaining any required Authorizations.

The office visit Copayment may be reduced when services are rendered by a Provider participating in the Quality Blue program. Quality Blue Providers include any Provider who has signed a contract to participate in the Quality Blue program. Currently, Quality Blue Providers include family practitioners, general practitioners, pediatricians, internists, geriatricians, nurse practitioners and physician assistants, but more Providers may contract to participate in the Quality Blue program. To verify if a Provider participates in the Quality Blue program, the Plan Participant may review a Provider directory on Our website at www.bcbsla.com or contact Our customer service department at the number on the ID card.

If one Provider directs a Plan Participant to another Provider, the Plan Participant 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, Benefits will be processed at the Non-Network Benefit level and the Allowable Charge applicable to that Provider.

AUTHORIZATIONS

We must Authorize some services and supplies before services are received. The Schedule of Benefits lists the services, supplies, and Prescription Drugs that require this advance Authorization.

No payment will be made for organ, tissue and bone marrow transplant Benefits or evaluations unless We Authorize these services and the services are 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 the ID card.

HOW WE DETERMINE WHAT WE PAY FOR COVERED SERVICES

When the Plan Participant uses Network Providers

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

When the Plan Participant uses Participating Providers

Participating Providers have signed a contract with Us or any other Blue Cross and Blue Shield plans to participate in their Provider Networks. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services. This amount is the Participating Provider's Allowable Charge and is used to determine the amount We pay for Medically Necessary Covered Services.

The Plan Participant has the right to file an Appeal with Us for consideration of Network Benefits if the Plan Participant received Covered Services from a Participating Provider who was the only Provider available to deliver the Covered

Service within a 75-mile radius of the Plan Participant's home. To file an Appeal, the Plan Participant must follow the Appeal procedures in this Benefit Plan.

When the Plan Participant uses Non-Participating Providers

Non-Participating Providers do not have a contract with the HMOLA Network, Blue Cross and Blue Shield of Louisiana or any other Blue Cross and Blue Shield plans. 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.

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

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

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

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

Note: The following example is for illustration purposes only and is not a true reflection of the Plan Participant's actual Copayments, Deductible Amounts, and Coinsurances. Please refer to the Schedule of Benefits to determine Benefits.

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

The Plan Participant receives Covered Services from:	Network Hospital	Participating Hospital	Non-Participating Hospital
Hospital Bill:	\$12,000	\$12,000	\$12,000
Allowable Charge:	\$2,500	\$3,000	\$2,500
Claims Administrator pays:	\$2,000	\$1,800	\$1,500
	\$2,500 Allowable Charge x 80% Coinsurance = \$2,000	\$3,000 Allowable Charge x 60% Coinsurance = \$1,800	\$2,500 Allowable Charge x 60% Coinsurance = \$1,500
Plan Participant pays:	\$500	\$1,200	\$1,000
	20% Coinsurance x \$2,500 Allowable Charge = \$500	40% Coinsurance x \$3,000 Allowable Charge = \$1,200	40% Coinsurance x \$2,500 Allowable Charge = \$1,000
Is Plan Participant billed up to the Hospital's billed charge?	NO	NO	YES – \$9,500
TOTAL AMOUNT PLAN PARTICIPANT PAYS:	\$500	\$1,200	\$10,500

WHEN A PLAN PARTICIPANT PURCHASES COVERED PRESCRIPTION DRUGS

Some pharmacies have contracted with 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 a Plan Participant's covered Prescription Drugs and the amount that the Plan Participant must pay for covered Prescription Drugs.

When the Plan Participant buys covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our Pharmacy Benefit Manager or when a Plan Participant files a paper Claim with Us 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, contact Our customer service department or Our Pharmacy Benefit Manager at the telephone number on the ID card.

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

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

PLAN PARTICIPANT INCENTIVES AND VALUE-ADDED SERVICES

Sometimes We may offer Plan Participants coupons, discounts, and incentives to enroll in programs, such as pharmacy programs, disease management programs, and wellness programs and activities. We may offer Plan Participants discounts or financial incentives to use certain Providers for selected Covered Services. We may also offer Plan Participants the opportunity to enroll in health and non-health related programs, as Value-Added Services, to enhance the Plan Participant's experience with Us or his Providers. These incentives and Value-Added Services are not Benefits and do not alter or affect Plan Participant Benefits. They may be offered by Us, affiliated companies, and selected vendors. Plan Participants 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 Plan Participants.

HEALTH MANAGEMENT AND WELLNESS TOOLS AND RESOURCES

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

CUSTOMER SERVICE EMAIL ADDRESS

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

IDENTITY PROTECTION SERVICES

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

1. Credit monitoring which monitors activity that may affect credit.
2. Fraud detection which identifies potentially fraudulent use of identity or credit.
3. Fraud resolution support that assists Plan Participants in addressing issues that arise in relation to credit monitoring and fraud detection.

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

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

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

Article 2. DEFINITIONS

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, Benefits will be provided for 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 one (1) day.

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

- A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment that is determined to be experimental or Investigational;
- B. the Plan Participant's eligibility for coverage under the Benefit Plan;
- C. any prospective or retrospective review determination;
- D. a Rescission; or
- E. a decision involving items and services within the scope of the surprise billing and cost-sharing protection requirements of the No Surprises Act.

Allied Health Facility – An institution, other than a Hospital, 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 –

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

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

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

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

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

Autism Spectrum Disorders (ASD) – Any 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. Autism Spectrum Disorders includes conditions such as Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified.

Bed, Board and General Nursing Service – Room accommodations, meals, and all general services and activities 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 Plan Participant 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 Plan Participants, the Benefit Period begins on the Effective Date and ends on December 31 of the same year.

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

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

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

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

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

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

Care Coordinator Fee – A fixed amount paid by Blue Cross and Blue Shield of Louisiana to Providers periodically for Care Coordination under a Value-Based Program.

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

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

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

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

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

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

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

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

Concurrent Care – Hospital Inpatient medical and Surgical care that a Physician who is not the attending Physician gives:

- A. for a condition that is not related to the primary diagnosis, or
- B. 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 as to the evaluation or treatment of a Plan Participant, which is furnished upon the request of the attending Physician. These services are not intended to include those consultations required by Hospital rules and regulations, anesthesia consultations, routine consultations for clearance for Surgery, or consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge.

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

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

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

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

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

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be 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, but are not limited to:

- A. Providing personal care, homemaking, moving the patient;
- B. Acting as companion or sitter;
- C. Supervising medication that can usually be self-administered;

- D. Treating or providing services that anyone may be able to perform with minimal instruction; or
- E. Providing long-term treatment for a condition in a patient who is not expected to improve or recover.

We determine which services are Custodial Care.

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

Deductible Amounts –

A. Individual Deductible Amount –

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

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

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

Dental Care and Treatment – All procedures, treatment, and Surgery considered to be within the scope of the practice of dentistry. Dentistry is the practice in which someone:

- A. represents himself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;
- B. takes impressions of the human teeth or jaws or performs any phase of any operation incident to replacing a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or
- C. furnishes, supplies, constructs, reproduces, or repairs or offers to furnish, supply, construct, reproduce, or repair prosthetic dentures, bridges, or other substitute for natural teeth to the user or prospective user.

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

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures We recognize as accepted medical practice, 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 a 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 when the Plan Participant's coverage begins under this Benefit Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 AM on this date.

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

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

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

Emergency – See Emergency Medical Condition.

Emergency Admission – An Inpatient Admission to a Hospital 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:

- A. placing the health of the person, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- B. serious impairment to bodily function; or
- C. serious dysfunction of any bodily organ or part.

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

- A. When within the capability of a Hospital or independent freestanding Emergency department, the following services and items:
 - 1. A medical screening examination, including ancillary services routinely available to the Emergency department to evaluate an Emergency Medical Condition.
 - 2. Further medical examination and such treatment as may be required to stabilize the medical condition, regardless of the department of the Hospital in which such further examination or treatment is furnished.
- B. With respect to an Emergency Medical Condition and regardless of the department of the Hospital where furnished, additional services that are:
 - 1. Covered Services under the Benefit Plan;
 - 2. Furnished after the Plan Participant is stabilized; and
 - 3. Part of an Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Medical Services are furnished.

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

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

Employer – The person, firm, or institution named on the Schedule of Benefits.

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

Erectile Dysfunction (ED) – A condition in which the Plan Participant 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 for immediate internal review of an Adverse Benefit Determination, which involves any of the following situations:

- A. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function.
- B. In the opinion of the treating Physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.
- C. A decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Plan Participant currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

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

- A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function.
- B. A decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Plan Participant currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.
- C. A denial of coverage based on a determination that the recommended or requested healthcare service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Plan Participant's health, including severe pain, potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the Plan Participant.

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

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

- A. employed on an average thirty (30) or more hours a week; or
- B. working fewer than thirty (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 Benefit Plan, unless the Employee is determined to be a Full Time Equivalent.

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

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

Gestational Carrier – A woman, not covered on the Benefit 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 – Employer or other legal entity who is the Plan Administrator and Sponsor of this Benefit Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

Habilitative Care – Healthcare services and devices that help a patient keep, learn or improve 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.

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

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

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

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 –

- A. Low-Tech Imaging – Imaging Services which include, but are not limited to, x-rays, machine tests, diagnostic imaging and radiation therapy.
- B. High-Tech Imaging – Imaging Services which include, but are not limited to, MRIs, MRAs, CT Scans, PET Scans, and nuclear cardiology.

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

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

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

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

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

Inpatient – A Plan Participant who is 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, twenty-four (24) hours a day. If the services can be safely provided as an Outpatient, the Plan Participant does not meet the criteria for an Inpatient.

Intensive Outpatient Programs – Programs that have the capacity for planned, structured, service for at least two (2) hours a day and three (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:

- A. 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
- B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation centers;
 2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. reference to federal regulations.

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

Medically Necessary (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:

- A. according to nationally accepted standards of medical practice;
- B. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for patients' illness, injury or disease; and
- C. 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.

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

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 one (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 Plan Participants. 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 PPO Provider Network or another PPO Network. We also call these Providers Preferred Providers or In-Network Providers.

Newly Born Infant – Infants from birth until one (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.

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

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

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

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

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

Open Enrollment – A period of time, designated by the Group, during which a Plan Participant and any eligible Dependents may enroll for Benefits under 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 the Plan Participant must pay for Covered Services in one (1) Benefit Period. For the specific dollar amount, see the Schedule of Benefits.

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

Over-Age Dependent – A Dependent child (or grandchild) who is age twenty-six (26) or older, reliant on the Plan Participant for support, and is incapable of sustaining employment because of an intellectual or physical disability that began prior to age 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 Us. We may require additional or periodic medical documentation regarding the Dependent child's intellectual or physical disability as often as We deem necessary, but not more frequently than once per year after the two-year period following the child's 26th birthday. We may terminate coverage of the Over-Age Dependent if We determine the Dependent child is no longer

reliant on the Plan Participant 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 four (4) hours a day and three (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 twenty-four (24) hours a day. Patients are not considered residents at the program. The range of services addresses a mental health and/or 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 – The Employer's medical Benefits plan for certain Employees of the Employer and is described in this document.

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

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

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

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

Pre-Existing Condition – A physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specific period of time 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, which includes Specialty Drugs, the sale or dispensing of which legally requires the order of a Physician or other healthcare professional and that carry the federally required product legend stipulating that such drugs may not be dispensed without a prescription, and which are currently approved by the FDA for safety and effectiveness, subject to the Limitations and Exclusions Article.

Prescription Drug Coinsurance – The share of Allowable Charges for Prescription Drugs that this Benefit Plan covers. The amount is calculated as a percentage. A percentage that We pay and a percentage that the Plan Participant pays. (For example, We pay 80% and You pay 20%.) After the Plan Participant pays any Prescription Drug Deductible Amount, We apply the Plan Participants 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 the Benefit. A different Prescription Drug Coinsurance may be required for the different drug tiers the Plan Participant buys at a pharmacy or through the mail.

Prescription Drug Copayment – The amount a Plan Participant 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 Benefit 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.

We determine which services are Private Duty Nursing Services. Private Duty Nursing Services that are determined by Us to be Custodial Care are not covered.

Prosthetic Appliance or Device – Appliances which replace all or part of a body organ or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part. 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, nose, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Prosthetic Services – The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis 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, licensed where required, performing within the scope of license, and approved by Us. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Plan Participants in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

- A. Preferred Provider – A Provider that has a signed 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.
- B. Participating Provider – A Provider that has a signed contract with Us or another Blue Cross and Blue Shield plan for other than a Preferred Care or PPO Network.
- C. Non-Participating Provider – A Provider that does not have a signed contract with Us or any other 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 covered persons.

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

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

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.

Remote Patient Therapy – A mode of delivering healthcare services that involves the collection of and electronic transmission of biometric data that are analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health condition. Remote Patient Therapy services must be ordered by a licensed Physician, physician assistant, advanced practice registered nurse, or other qualified healthcare Provider who has examined the patient and with whom the patient has an established, documented, and ongoing relationship.

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

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

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

Retail Health Clinic – A non-Emergency medical health clinic 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:

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

Skilled Nursing Facility or Unit – A facility licensed by the state in which it operates and is 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:

- A. Inpatient medical care, treatment and skilled nursing care as defined by Medicare and that meets the Medicare requirements for this type of facility;
- B. Full-time supervision by at least one (1) Physician or registered nurse;
- C. 24-hour nursing service by registered nurses or licensed practical nurses; and
- D. Utilization review plans for all patients.

Special Care Unit – A designated Hospital unit which 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 thirty (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 have one (1) or more of the following characteristics:

- A. Required specialized patient training on administering the drug (including supplies and devices needed for administration);

- B. Required coordination of care before drug therapy starts or during therapy;
- C. Unique patient compliance and safety monitoring requirements;
- D. Unique requirements for handling, shipping, and storing the drug; and
- E. Restricted access or limited distribution.

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

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

Spouse – The Plan Participant's legal Spouse.

Surgery –

- A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic exams, incisional and excisional biopsies and other invasive procedures.
- B. The correction of fractures and dislocations.
- C. Pregnancy Care to include vaginal deliveries and cesarean sections.
- D. Usual and related pre-operative and post-operative care.
- E. 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 the Provider and patient are in separate locations.

- A. Asynchronous Telehealth Services – the transmission of a patient's pre-recorded medical information from an originating site to the Provider at a distant site without the patient being present.
- B. Synchronous Telehealth Services – the interaction between patient and Provider in different locations in real time, by means of two-way video and audio transmission, usually through an established patient portal.

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

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

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

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

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

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

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

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 twenty-four (24) months old for whom no diagnosis is made.

Article 3. SCHEDULE OF ELIGIBILITY

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

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

A. Eligibility

1. Employee. To be eligible to enroll as an Employee, an individual must be:
 - a. an Employee, who is an active, regular Employee of the Employer, who works the required number of hours for coverage, as designated by the Employer.
 - b. a retiree who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Benefits.
 - c. an elected official who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Benefits.
2. Dependent. To be eligible to enroll as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by Us that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Benefit Plan.
 - a. Spouse.
 - b. Children: A child under age twenty-six (26) who is one of the following:
 - (1) born of the Employee; or
 - (2) legally placed for adoption with the Employee; or
 - (3) legally adopted by the Employee; or
 - (4) a child for whom the Employee or his Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Employee or his Spouse is a court appointed tutor/tutrix; or
 - (5) a child supported by the Employee pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN). Employees and beneficiaries of this Benefit Plan may obtain, without charge, a description of procedures for QMCSO determinations from the Plan Administrator; or
 - (6) a stepchild of the Employee; or
 - (7) a grandchild residing with the Employee, provided the Employee has been granted legal custody or provisional custody by mandate of the grandchild; or
 - (8) the Employee's child or grandchild who is in the legal custody of and residing with the Employee, who is covered on the Plan before turning age twenty-six (26) and is able to remain covered on the Plan once turning age twenty-six (26) because he meets the definition and requirements of an Over-Age Dependent.

B. Enrollment for Coverage

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

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

C. Available Classes of Coverage

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

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

D. Effective Date

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

1. If a person is an Eligible Person on this Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, this Group's Benefit Plan Date will be the Effective Date of coverage.
2. If a person becomes an Eligible Person after this Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) and the enrollment form is received by Us within thirty (30) days of the eligibility date, the Effective Date of coverage will be the eligibility date.
3. If an Eligible Person's application for coverage for self or for self and any eligible Dependent(s) is not received by Us within thirty (30) days of the eligibility date or special enrollment period as described below, the request for enrollment will be denied. The Eligible Person shall be eligible to enroll for coverage during the next Open Enrollment period.
4. If a child is born to an Employee holding coverage which includes Dependent children (Employee and Family coverage or Employee and Child(ren) coverage), and the enrollment form is received by Us within one hundred eighty (180) days of the date of birth, the Effective Date of coverage will be the date of birth.

E. Court Ordered Determination

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

F. Special Enrollment

1. Special Enrollment Due to Loss of Certain Other Coverage

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

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

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

- a. The Eligible Person must be eligible for coverage under the terms of this Benefit Plan;
- b. The Eligible Person must have declined enrollment under this Benefit Plan when offered;
- c. The Eligible Person lost coverage under a plan considered Creditable Coverage for HIPAA Portability purposes;
- d. The Eligible Person's coverage described in c. above:
 - (1) was under a COBRA continuation provision and the COBRA continuation period was exhausted due to one of the following:
 - (a) the full COBRA continuation period was exhausted
 - (b) the Employer or other responsible entity failed to remit required premiums or contributions on a timely basis;
 - (c) the individual whose coverage is through a health maintenance organization (HMO), no longer lives, resides or works in the service area the HMO services, whether or not the choice of the individual in the service area, and there is no other COBRA coverage available;
 - (2) was not under a COBRA continuation provision and lost other health coverage due to:
 - (a) loss of eligibility for coverage. Loss of eligibility for coverage includes 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 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 not 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 thirty (30) days after other coverage ends (or after the Employer stops contributing toward the other non-COBRA coverage). If We receive this enrollment within thirty (30) days after loss of other coverage, coverage will become effective on the date other coverage is lost. If the enrollment is not received within thirty (30) days of the loss of other coverage but is received within sixty (60) days of loss of other coverage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if We do not receive the request for enrollment form within sixty (60) days of the loss of other coverage.

- 2. Special Enrollment of a Dependent Child Due to Loss of Coverage under the Children's Health Insurance Program or a Medicaid Program
 - a. This Benefit Plan provides a special enrollment period for an Employee or family Dependent(s) if either (1) they are covered under Medicaid or State Children's Health Insurance Program (CHIP) and lose that coverage because of loss of eligibility; or (2) they become eligible for premium assistance under the CHIP program. To qualify, the Employee must request coverage in this Benefit Plan no later than sixty (60) days after either the date of coverage termination under Medicaid or CHIP or the date the Employee or the Dependent is determined to be eligible for such premium assistance. A request for special enrollment under this section must be received by Us within the sixty (60) day period following loss of coverage or the date the Employee or the Dependent is determined to be eligible for premium assistance. When special enrollment under this section is made timely and received by Us timely, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP or the date the Employee or the Dependent is eligible for premium assistance.
 - b. An Employee may disenroll a Dependent child from this coverage and enroll the child in CHIP coverage effective on the first day of any month for which the child is eligible for such CHIP coverage. The Employee must promptly notify Us in writing of the child's disenrollment to avoid continued coverage under this Benefit Plan.
- 3. Special Enrollment Due to Acquiring a Dependent
 - a. This Benefit Plan shall provide for a special enrollment period during which the Dependent of a participating Employee, elected official, officer or director may be enrolled in the plan. If not already participating, a current Employee, elected official, officer or director may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period.

Retirees who are not currently participating do not have these special enrollment rights for adding Dependents and may not enroll in the plan for this reason.

- b. A person becomes a Dependent of the covered or eligible Employee, elected official, officer or director through marriage, birth, adoption, or placement for adoption. In the case of the birth, adoption, or placement for adoption of a child, the Spouse of the Employee, elected official, officer or director may be enrolled as a Dependent if he is otherwise eligible for coverage.
- c. If the Plan Administrator offers multiple health plan options, another option may be chosen by the current Employee, elected official, officer or director for himself and Dependents when Special Enrollee status applies.
- d. The special enrollment period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied.
- e. In the case of a birth, adoption, or placement for adoption, a current Employee may enroll himself, his Spouse and/or the newborn/adopted child and other eligible Dependent children. The enrollment must be

requested by signing an enrollment form no later than thirty (30) days after the birth, adoption, or placement for adoption.

If the signed enrollment form is received by Us no later than thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth for a natural Newly Born Infant, and upon the date of adoption, or placement for adoption for an adopted Newly Born Infant. An Employee may enroll an unborn natural child prior to birth; however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth.

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

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

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

- g. For Plan Participants holding Employee and Family coverage or Employee and Child(ren) coverage:

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

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

Article 4. BENEFITS

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

A. Benefit Categories

1. Network Benefits (In-Network) – Benefits for medical care received from a Preferred Care Provider. When a Plan Participant receives care from a Network Provider, the Plan Participant will receive the highest level of Benefits on this Benefit Plan.
2. Non-Network Benefits (Out-of-Network) – Benefits for medical care received from a Provider who is not contracted with Us as a Preferred Care PPO Provider. Participating Providers and Non-Participating Providers are not contracted with Our Preferred Care PPO Network. When a Plan Participant receives care from a Non-Network Provider, the Plan Participant will receive a lower level of Benefits on this Benefit Plan.

B. Deductible Amounts and Coinsurance

1. Subject to the Deductible Amounts shown on the Schedule of Benefits, the maximum limitations hereinafter provided, and other terms and provisions of this Benefit Plan, We will provide Benefits in accordance with the Coinsurance shown on the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period. The following Deductible Amounts may apply to covered Benefits provided by this Benefit Plan. Deductible Amounts will accrue to the Out-of-Pocket Amount.
 - a. Individual Deductible Amount: The dollar amount, as shown on the Schedule of Benefits, of charges for Covered Services that the Plan Participant must pay within a Benefit Period before this Benefit Plan starts paying Benefits. A separate Deductible Amount may apply to certain covered Services if shown as applicable on the Schedule of Benefits.
 - b. Family Deductible Amount: The dollar amount, as shown on the Schedule of Benefits, for each category of Benefits to which a Deductible Amount applies. Once a family has met its Family Deductible Amount, this Benefit Plan starts paying Benefits for all members of the family, regardless of whether each individual has met the Individual Deductible Amount.
 - c. Prescription Drug Deductible Amount: The dollar amount, if shown on the Schedule of Benefits, which each Plan Participant must pay within a Benefit Period prior to paying a Prescription Drug Copayment or Coinsurance. The Prescription Drug Deductible Amount does not accrue to the Benefit Period Deductible Amount or the Family Deductible Amount.
 - d. Coinsurance Amount: The Coinsurance is shown on the Schedule of Benefits for a Covered Service. The Plan Participant must first pay any applicable Deductible Amount before the Coinsurance. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Benefit Plan will provide Benefits in the Coinsurance shown on the Schedule of Benefits toward Allowable Charges for Covered Services. The actual payment to a Provider or payment to the Plan Participant satisfies the Plan Administrator's obligation to provide Benefits under this Benefit Plan.
2. Each Deductible on the Schedule of Benefits may have separate In-Network and Out-of-Network amounts.
3. We will apply Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by Us. Our system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays the Deductible Amount, the Plan Participant is entitled to receive a refund from the Provider in which the overpayment was made.

4. Under certain circumstances, if We pay the healthcare Provider amounts that are the Plan Participant's responsibility, such as Deductible Amounts, Copayments or Coinsurance, We may collect such amounts directly from the Plan Participant. The Plan Participant agrees that We have the right to collect such amounts from the Plan Participant.

C. Copayment Services

If a Copayment is shown on the Schedule of Benefits, the Plan Participant may pay one or more Copayments each time applicable Covered Services are rendered. The amount of the Copayment depends on the service and the type of Network Provider rendering the service. Office visit Copayments, if applicable, will be shown on the Schedule of Benefits.

If applicable, the office visit Copayment may be reduced when services are rendered by a Quality Blue Provider. Quality Blue Providers include any Provider who has signed a contract to participate in the Quality Blue program.

1. Examples of Covered Services performed in the Physician's office which are subject to Copayments:
 - a. Office visits and consultations;
 - b. Surgical procedures;
 - c. Injections, allergy serums, and vials of allergy medications;
 - d. Dialysis;
 - e. Chemotherapy;
 - f. Infusion therapy; and
 - g. Diabetes education.
2. The following services are covered at one hundred percent (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 therapy;
 - 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.

D. Out-of-Pocket Amount

1. After the Plan Participant has met the applicable Out-of-Pocket Amount, as shown on the Schedule of Benefits, We will pay one hundred percent (100%) of the Allowable Charges for Covered Services for the remainder of the Benefit Period.
2. The following accrue to the Out-of-Pocket Amount of this Benefit Plan:
 - a. Coinsurance
 - b. Benefit Period Deductible Amount
 - c. Copayments
3. The following do not accrue to the Out-of-Pocket Amount of this Benefit Plan:
 - a. any charges that are more than the Allowable Charge;
 - b. any penalties the Plan Participant or Provider must pay;
 - c. charges for non-covered services; and
 - d. any other amounts paid by the Plan Participant other than Deductible Amounts, Coinsurance and Copayments.
4. Amounts paid by Plan Participants for Covered Services provided by Participating and Non-Participating (collectively Non-Network) Providers will accrue to the Out-of-Pocket Amount for Network Providers when required by law.

E. Accumulator Transfers

Plan Participants' 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 a Blue Cross and Blue Shield of Louisiana policy to an HMO Louisiana, Inc. policy. The type of transfer being made determines whether the Plan Participant's accumulators are carried from the old policy to the new policy. Accumulators include, but are not limited to, Deductible Amounts, Out-of-Pocket Amounts, and Benefit Period maximums.

Article 5. HOSPITAL BENEFITS

We must Authorize All Admissions (including elective or non-Emergency, Emergency, Pregnancy Care, Mental Health and substance use disorders Admissions) as shown in the Care Management Article 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. The Plan Participant must pay any Deductible Amount, Copayment, and Coinsurance shown on the Schedule of Benefits.

If the Plan Participant receives services from a Physician in a Hospital-based clinic, the Physician, the clinic, and the facility may charge the Plan Participant.

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Plan Participant 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 Plan Participants with Mental Health, substance use disorder.

B. Other Hospital Services (Inpatient and Outpatient)

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

C. Emergency Room Benefits

1. Hospital Facility Services

An Emergency room Copayment, if shown on the Schedule of Benefits, applies to each visit to an Emergency room for treatment. The Emergency room Copayment is waived if the visit results in an Inpatient Admission.

Benefits for Professional Services received in the Emergency room of a Hospital will be subject to the Deductible Amount and Coinsurance shown on the Schedule of Benefits.

2. Professional Services

A Copayment, if shown on the Schedule of Benefits, applies to Emergency Medical Services rendered by the treating Physician for each visit to an Emergency room.

D. Pre-Admission Testing

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

Article 6. MEDICAL AND SURGICAL BENEFITS

Benefits for the following medical and Surgical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. A Plan Participant must pay any applicable Deductible Amounts, Copayments and Coinsurance 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, any incidental service will not be covered.

d. Unbundled Services

- (1) Unbundling occurs when two (2) or more service codes are used to describe a medical or Surgical service performed when a single, more comprehensive service code exists that accurately describes

the entire medical or Surgical service performed. The unbundled services are considered included in the proper comprehensive service code as determined by Us.

- (2) The Allowable Charge of the comprehensive service code includes the charge for 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. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by Us. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.
- b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless We determine otherwise.
- c. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

5. Second Surgical Opinion

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

B. Inpatient Medical Services

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 Benefit Plan).
3. Diagnostic Services.
4. Services of an Ambulatory Surgical Center.
5. Services of an Urgent Care Center.

Article 7. PRESCRIPTION DRUG BENEFITS

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

- A. The Prescription Drugs must be dispensed on or after the Plan Participant's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that We determine and only those Prescription Drugs that We determine are Medically Necessary will be covered. Certain Prescription Drugs may be subject to Step Therapy or require prior Authorization as shown on the Schedule of Benefits.
- B. Some pharmacies have contracted with Us or with Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are Participating Pharmacies. Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is based on the amount We pay Our Pharmacy Benefit Manager. We use the amount We pay our Pharmacy Benefit Manager to base Our payment for the Plan Participant's covered Prescription Drugs and the amount that the Plan Participant must pay for covered Prescription Drugs.

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

- C. The Plan Participant should present the ID card to the pharmacist when purchasing covered Prescription Drugs at a Participating Pharmacy. The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. If the Plan Participant has not met the 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 Plan Participant has met the 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 Plan Participant.
- D. Prescription Drug Formulary

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

Information about the formulary is available in several ways. Most Plan Participants receive information 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 the ID card.

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

1. Open Prescription Drug Formulary

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

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

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 Plan Participant may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Plan Participant may be required to pay a different Copayment or Coinsurance depending on whether the Plan Participant's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.

(2) The Prescription Drug Copayment or Coinsurance is based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. The Plan Participant may call customer service or go to www.bcbsla.com/pharmacy to identify the tier classification of the 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 on the Schedule of Benefits. Generic Drugs and Brand-Name Drugs may be subject to different Coinsurances.

(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 Plan Participant may be required to pay a

different Copayment or Coinsurance for the different drug tiers. The Plan Participant may be required to pay a different Copayment or Coinsurance depending on whether the Plan Participant's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.

- (2) The Prescription Drug Copayment or Coinsurance is based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. The Plan Participant may call customer service or go to www.bcbsla.com/pharmacy to identify the tier classification of the 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 the Plan Participant's prescribing healthcare Provider to ask for a drug review from Us. This request must be based on Medical Necessity. If the request is approved, the Plan Participant will receive coverage for the drug that is not on the Prescription Drug Formulary. If the drug review request is not approved, the Plan Participant may file an internal or external drug review request to 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 Plan Participant may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Plan Participant may be required to pay a different Copayment or Coinsurance depending on whether the Plan Participant's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.

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

- (3) If a drug review request is approved, the Plan Participant will receive coverage for the drug that is not on the Prescription Drug Formulary at Tier 3 if it is a non-Specialty Drug and at Tier 4 if it is a Specialty Drug.

- (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 on the Schedule of Benefits. Generic Drugs and Brand-Name Drugs may be subject to different Coinsurances.
- (2) If a drug review request is approved, the Plan Participant will receive coverage for the drug that is not on the Prescription Drug Formulary at the applicable Generic Drug or Brand-Name Drug cost share.

- (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 Plan Participant may be required to pay a different Copayment or Coinsurance depending on whether the Plan Participant's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.
- (2) The Prescription Drug Copayment or Coinsurance is based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. The Plan Participant may call customer service or go to www.bcbsla.com/pharmacy to identify the tier classification of the Prescription Drug.
- (3) If a drug review request is approved, the Plan Participant will receive coverage for the drug that is not on the Prescription Drug Formulary at the highest drug tier (Plan Participant 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 Plan Participant safety, appropriate and cost-effective use of medications, and monitor healthcare quality. Examples of these programs include:

- 1. Prior Authorization – As part of Our Drug Utilization Management program, Plan Participants and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on Our website at

www.bcbsla.com/pharmacy or by calling the customer service telephone number on the ID Card. If the Prescription Drug requires prior Authorization, the Plan Participant's Physician must call the medical Authorization telephone number on the ID Card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.

2. Safety checks – Before the Plan Participant's prescription is filled, 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 Plan Participant 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 Plan Participant's medical condition, We may require the Plan Participant's Physician to prescribe Drug A first. If Drug A does not work for the Plan Participant, then We will cover a prescription written for Drug B. However, if the Plan Participant's Physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if the Plan Participant chooses a Step B drug included in the Step Therapy program without first trying a Step A alternative, the Plan Participant will be responsible for the full cost of the drug.
5. Step Therapy Overrides – The Plan Participant's Provider prescribing the Prescription Drug may request a Step Therapy override.
 - a. Step Therapy overrides are provided for stage-four advanced, metastatic cancer or associated conditions when certain criteria exist; step therapy overrides are also provided for other conditions when certain criteria are met.
 - b. When a Step Therapy Override request is submitted, We will respond to the request within seventy-two (72) hours unless exigent circumstances exist, in which case We will respond to the request within twenty-four (24) hours. If We do not make the determination timely, then the override request is considered approved.
 - c. If a Step Therapy Override request is denied, an Appeal can be submitted.
- F. Select diabetic supplies, including, but not limited to, necessary continuous glucose monitors and associated supplies, insulin syringes, and test strips are covered under the Prescription Drug Benefit.
- G. When a Plan Participant purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our Pharmacy Benefit Manager or when a Plan Participant files a paper Claim with Us or Our Pharmacy Benefit Manager, the Allowable Charge is the amount that We pay 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 Plan Participant should submit Claims on Our Prescription Drug Claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Plan Participant should contact Us or Our Pharmacy Benefit Manager at the telephone number indicated on the ID card.
- I. As part of Our administration of Prescription Drug Benefits, We may disclose information about the Plan Participant's Prescription Drug utilization, including the names of Your prescribing Physicians, to any treating Physicians or dispensing pharmacies.

- J. Any savings or rebates We receive on the cost of drugs purchased under this Benefit Plan from drug manufacturers are used to stabilize rates. Plan Participants 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. PREVENTIVE OR WELLNESS CARE

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

A. Well Woman Examinations

1. Routine annual visits to an obstetrician, gynecologist or other Physician. Additional visits recommended by the Plan Participant's obstetrician or gynecologist, or other Physician may be subject to the Deductible Amount, Copayment or Coinsurance shown on the Schedule of Benefits, if not a preventive service.
2. One (1) routine Pap smear per Benefit Period.
3. All film mammograms, 3-D mammograms (digital breast tomosynthesis), and breast ultrasounds are covered at no cost to the Plan Participant when obtained from a Network Provider. If the Plan Participant goes to a Non-Network Provider, the Plan Participant 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 on the Schedule of Benefits for High-Tech Imaging Services. Any MRIs that are not covered under this Preventive or Wellness Care Benefit may be covered under standard Benefits for High-Tech Imaging Services when Medically Necessary.

B. Physical Examinations and Testing

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

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

2. Well Baby Care - Routine examinations will be covered for infants under the age of twenty-four (24) months for whom no diagnosis is made. Routine examinations ordered after the infant reaches twenty-four (24) months will be subject to the Routine Wellness Physical Exam Benefit.
3. Prostate Cancer Screening – One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, is covered for Plan Participants fifty (50) years of age or older, and as recommended by his Physician if the Plan Participant is over forty (40) years of age.

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

4. Colorectal Cancer Screening – Fecal immunochemical test (FIT) for blood, 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 or Wellness Care Benefit will be at no cost to the Plan Participant when obtained from a Network Pharmacy. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Plan Participant only when the Physician prescribes brand-name colonoscopy preparation and supplies because of the Plan Participant's inability to tolerate selected generic colonoscopy preparation and supplies.

5. Bone Mass Measurement – scientifically proven tests for the diagnosis and treatment of osteoporosis if a Plan Participant is:
 - a. an estrogen-deficient woman 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 Plan Participants 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 six (6).
2. Immunizations recommended by the Plan Participant's 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 the ID card.

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

E. COVID-19 Services

Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by a Plan Participant's Physician for the purpose of making clinical decisions or treating a Plan Participant suspected of having COVID-19 are covered under this Benefit Plan. When a Plan Participant receives these services from a Network or Non-Network Provider, Benefits will be covered, up to the Network Allowable, at no cost when required by applicable law. Non-Network Providers are able to balance bill Plan Participants up to their full-billed charge. Balance bills do not accrue to the Out-of-Pocket Amount. When not required by applicable law to be covered at no cost, these services

are subject to standard Benefits, including applicable Deductible Amounts and Coinsurances, as shown on the Schedule of Benefits for Network or Non-Network Providers.

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

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

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

F. New Recommended Preventive or Wellness Care Services

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

Article 9. MENTAL HEALTH BENEFITS

- A. Benefits for the treatment of Mental Health are covered. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Coverage for treatment of Mental Disorders does not include counseling services such as career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling.
- B. The first follow-up visit after discharge from an Inpatient facility for the treatment of a Mental Disorder is available at no cost to the Plan Participant 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 standard Benefits.

Article 10. SUBSTANCE USE DISORDER BENEFITS

- A. Benefits for treatment of substance use disorders are available. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.
- B. The first follow-up visit after discharge from an Inpatient facility for the treatment of a substance use disorder is available at no cost to the Plan Participant when performed within seven (7) days of the discharge by a Network Provider approved by Us as a behavioral health Provider. Additional visits will be paid subject to standard Benefits.

Article 11. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, Providers in the Preferred Care PPO Network, the United Concordia Dental Advantage Plus Network or Blue Cross and Blue Shield of Louisiana's dental Network are considered Network Providers. Access these Networks online at www.bcbsla.com, or call the customer service telephone number on the ID card for copies of the directories. The highest level of Benefits are available when services are performed by a PPO Provider, or by a Provider in Blue Cross and Blue Shield of Louisiana's dental Network. Access the dental Network online at www.bcbsla.com, or call the customer service telephone number on the ID card for a copy of the directory.

A. Coverage is provided only for 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 a Plan Participant's 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 the Schedule of Benefits.

B. Benefits for Head and Neck Cancer Patients

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

Article 12. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

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

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

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplants

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) for the specific organ or transplant or by a Blue Cross and Blue Shield of Louisiana Preferred Provider approved facility, unless otherwise approved by Us in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities. To locate an approved transplant facility, Plan Participants should contact Our customer service department at the number listed on the ID card.
2. Benefits for organ, tissue and bone marrow transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).
3. Benefits as specified in this section will be provided for treatment and care as a result of or directly related to the following transplant procedures:

a. Solid Human Organ Transplants of the:

- (1) liver;
- (2) heart;
- (3) lung;
- (4) kidney;
- (5) pancreas;
- (6) small bowel; and
- (7) other solid organ transplant procedures which We 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 and do not require prior Authorization. However, if an Inpatient Admission is required, it is subject to the Article on Care Management.

The following tissue transplants are covered:

- (1) blood transfusions;
- (2) autologous parathyroid transplants;
- (3) corneal transplants;
- (4) bone and cartilage grafting;
- (5) skin grafting;
- (6) autologous islet cell transplants; and
- (7) other tissue transplant procedures which We 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 Benefit 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. PREGNANCY CARE AND NEWBORN CARE BENEFITS

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

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

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

The Plan Participant must pay all applicable Copayments, Deductible Amounts and Coinsurance shown on the Schedule of Benefits.

A. Pregnancy Care Benefits

1. Medical and Surgical Services.
 - a. Initial office visit and visits during the term of the pregnancy.
 - b. Diagnostic Services.
 - c. Delivery, including necessary pre-natal and post-natal care.
 - d. Medically Necessary abortions required in order to save the life of the mother.
2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above are covered. The Hospital (nursery) charge for 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 Plan Participant under this Benefit Plan is the father.
3. 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.

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

1. Medical and Surgical services rendered by a Physician, for treatment of illness, pre-maturity, post-maturity, congenital condition and circumcision of a newborn are covered. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.
2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, pre-maturity, post-maturity, and congenital condition of a newborn are covered. Charges

for services for a well newborn, including the Hospital (nursery) charge, should not be billed separately from the mother's Hospital bill. As determined by Us, well newborn charges may be covered if the Plan Participant under this Benefit Plan is the father.

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

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

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

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

Article 14. REHABILITATIVE AND HABILITATIVE CARE BENEFITS

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

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

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

A. Occupational Therapy

1. Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his license, including, but not limited to a licensed occupational therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.
2. Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.
3. Prevention, wellness and education related services for Occupational Therapy do not require a referral.

B. Physical Therapy

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

2. A licensed physical therapist may perform an initial evaluation or Consultation of a screening nature to determine the need for Physical Therapy.
3. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances, if listed as a Covered Service:
 - a. To children who have a diagnosed developmental disability according to the plan of care.
 - b. As part of a Home Health Care agency according to the plan of care.
 - c. To a patient in a nursing home according to the 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 an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered when performed by a Provider 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, but not limited to, a speech pathologist or by an audiologist.
2. The therapy must be used to improve or restore speech/language or swallowing function.
3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to the receipt of services.

D. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of that license.
2. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for rehabilitation of a patient and may order diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

Article 15. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. Acupuncture Benefits

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

B. Ambulance Service Benefits

1. Ground Ambulance Transport Services

a. Emergency Transport

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

- (1) for Plan Participants, to the nearest Hospital capable of providing services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care;
- (2) for a Newly Born Infant, to the nearest Hospital or neonatal Special Care Unit 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, upon recommendation by the mother's attending Physician or her need professional Ambulance Service.

b. Non-Emergency Transport

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

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

- (1) unable to get up from bed without assistance; and
- (2) unable to ambulate; and
- (3) unable to sit in a chair or wheelchair.

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

2. Ground Ambulance Without Transport

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

3. Air Ambulance Transport Services

a. Emergency Transport

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

Benefits for air Ambulance Services are also available for Emergency transport when the Plan Participant is in a location that cannot be reached by ground Ambulance.

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

b. Non-Emergency Transport

Benefits for non-Emergency air Ambulance Services must be Authorized by 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 Plan Participants, to the nearest facility or Hospital capable of providing services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care. Once Authorized, the Plan Participant should verify the Network participation status of the air Ambulance Service Provider in the state or area where the pick-up is to occur, based on the zip code. To locate a Network Provider in the state or area, go to the Blue National Doctor & Hospital Finder at <http://provider.bcbs.com> or call 1-800-810-2583.

4. Ambulance Service Benefits will be provided as follows:

- a. If a Plan Participant pays a periodic fee to an ambulance membership organization with which We do not have a Provider agreement, Benefits for expenses incurred by the Plan Participant for its Ambulance Services will be based on any obligation the Plan Participant must pay that is not covered by the fee. If there is in effect a Provider Agreement between Us and the ambulance organization, Benefits will be based on the Allowable Charge.
- b. The medical transport services must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits.
- c. No benefits are available if transportation is provided for a Plan Participant's comfort or convenience.
- d. No Benefits are available when a Hospital transports Plan Participants between parts of its own campus or between facilities owned or affiliated with the same entity.

C. Attention Deficit/Hyperactivity Disorder

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

D. Autism Spectrum Disorders

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

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

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

1. Under the Women's Health and Cancer Rights Act, a Plan Participant who is receiving Benefits in connection with a mastectomy and elects breast reconstruction will also receive Benefits for the following Covered Services:
 - a. All stages of reconstruction of the breast on which the mastectomy has been performed or reconstruction of both breasts if a bilateral mastectomy has been performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to contralateral prophylactic mastectomy liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical Complications which may require additional reconstruction in the future;

- c. Prostheses; and
- d. Treatment of physical Complications of all stages of the mastectomy, including lymphedemas.

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

2. Certain breast cancer survivors are eligible to receive annual preventive cancer screening as part of long-term survivorship care. Plan Participants 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 Plan Participant. Annual preventive cancer screenings under this Benefit are subject to Deductible Amount, Copayment and Coinsurance.

F. Cleft Lip and Cleft Palate Services

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

1. Oral and facial Surgery, surgical management, and follow-up care.
2. Prosthetic treatment, such as obturators, speech appliances, and feeding appliances.
3. Orthodontic treatment and management.
4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.
5. Speech-language evaluation and therapy.
6. Audiological assessments and amplification devices.
7. Otolaryngology treatment and management.
8. Psychological assessment and counseling.
9. Genetic assessment and counseling for patient and parents.

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

G. Clinical Trial Participation

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

2. A Qualified Individual under this section means a Plan Participant 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 the individual's participation in a trial would be appropriate based upon the individual meeting the requirements in paragraph a, above; or
 - (2) The Plan Participant provides medical and scientific information establishing that the Plan Participant's participation in the trial would be appropriate based on the Plan Participant 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 reviewed by the Food and Drug Administration.
 - c. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
 - d. The study or investigation is conducted by any of the Departments listed below, which study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines:
 - (1) to be comparable to the system of peer review of studies and investigations of the National Institutes of Health, and
 - (2) assures 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 following services are not covered:
 - 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; and/or
 - d. Services, treatment or supplies not otherwise covered under this Benefit Plan.
5. Treatments and associated protocol-related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:
 - a. The treatment is provided with a therapeutic or palliative intent for patients with cancer or other Life-Threatening Illness or for the prevention or early detection of such diseases.
 - b. The treatment is 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.

H. Diabetes Benefits

1. Diabetes Education and Training for Self-Management
 - a. Plan Participants that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by the Plan Participant's treating Provider.
 - b. Evaluation and training programs for diabetes self-management is covered subject to the following:
 - (1) The program must be prescribed by the Plan Participant's treating Provider and provided by a licensed healthcare professional who certifies that the Plan Participant has successfully completed the training program.
 - (2) The program complies with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

2. Diabetic Retinal Screening

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

I. Dietitian Visits

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

J. Disposable Medical Equipment and Supplies

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

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

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

1. Durable Medical Equipment

- a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be mainly for comfort or convenience of the Plan Participant or others. 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 the patient's home.
- b. Benefits for rental or purchase of Durable Medical Equipment.
 - (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge).
 - (2) At Our option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.
 - (3) When Durable Medical Equipment is approved by Us, Benefits for standard equipment will be provided toward any deluxe equipment.

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

 - (a) that do not serve a medical purpose;
 - (b) that are not required to complete daily living activities;
 - (c) that are solely for the Plan Participant's comfort or convenience; or
 - (d) that are not determined by Us to be Medically Necessary.
 - (4) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.

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

c. Limitations for Durable Medical Equipment.

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

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

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

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

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

2. Orthotic Devices

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

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

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

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

(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 Plan Participant's comfort or convenience; or

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

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

d. No Benefits are available for supportive devices for the foot, except when used to treat diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

Benefits will be available for the purchase of Prosthetic Appliances and Devices (other than limb prosthetics and services) that are Authorized by Us, subject to the following:

- a. There is no coverage for fitting or adjustments as these are included in the Allowable Charge for the Prosthetic Appliance or Device.
- b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.
- 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 Plan Participant's comfort or convenience; or
 - (d) that are not determined by Us to be Medically Necessary.
 - (2) Regardless of claim 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

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

- a. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.
- b. When Prosthetic Appliances or Devices are approved by Us, Benefits for standard appliances or devices will be provided toward any deluxe appliance or device.
 - (1) Deluxe appliances or devices or deluxe features and functionalities of appliances or devices are those:
 - (a) that do not serve a medical purpose;
 - (b) that are not required to complete daily living activities;
 - (c) that are solely for the Plan Participant's comfort or convenience; or
 - (d) that are not determined by Us to be Medically Necessary.
 - (2) Regardless of claim 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. A Plan Participant may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Benefit Plan and may pay the difference between the price of the appliance or device and the Benefit payable, without financial or contractual penalty to the Provider of the appliance or device.
- d. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

L. Erectile Dysfunction Benefits

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

1. The services are available only to Plan Participants 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 the Schedule of Benefits.
3. Coverage for penile implants is limited to one (1) per lifetime.
4. Coverage for treatment (i.e., removal, repair, re-implantation) resulting from complications of the one covered penile implant is subject to Medical Necessity.
5. Coverage for provision of vacuum assisted devices (male vacuum erection system) will be covered as specified in the Durable Medical Equipment section of this Benefit Plan and is subject to the limitations included therein, including the five (5) year replacement limitation.
6. Sex therapy for treatment of sexual dysfunction other than Erectile Dysfunction is not covered.

M. Gene Therapy and Cellular Immunotherapy Benefits

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

N. Genetic or Molecular Testing for Cancer

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

O. Hearing Benefits

1. Hearing Benefits for Plan Participants age 17 and under

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

This Benefit is subject to payment of the applicable Copayment, Deductible Amount and Coinsurance.

2. Hearing Benefits for Plan Participants age 18 and older

Benefits are available for hearing aids for covered Plan Participants age eighteen (18) and older for severe hearing loss or profound hearing loss and when obtained from a Network Provider. Severe hearing loss or profound hearing loss is defined as hearing loss of 71dB or higher. This Benefit is limited to one (1) hearing

aid for each ear with severe hearing loss or profound hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate for the Plan Participant.

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

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

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

Benefits are available for cochlear implants and bone-anchored hearing aids (BAHA) for all eligible Plan Participants with severe hearing loss or profound hearing loss, regardless of age, the same as any other service or supply.

This Benefit is subject to Medical Necessity and payment of the applicable Copayment, Deductible Amount and Coinsurance.

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

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

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

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

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

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

P. High-Tech Imaging Services

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

Q. Home Health Care

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

R. Hospice Care

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

S. Interpreter Expenses for the Deaf or Hard of Hearing

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

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

Low Protein Food Products to treat certain Inherited Metabolic Diseases are covered. Inherited Metabolic Disease is a disease caused by an inherited abnormality of body chemistry. Low Protein Food Products are especially formulated to have less than one (1) 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:

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

U. Lymphedema Benefit

Treatment of lymphedema is covered 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, but is not limited to, multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

V. Permanent Sterilization Procedures

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

W. Prescription Donor Human Breast Milk

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

X. Prescription Drugs

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

Y. Private-Duty Nursing Services

1. This Benefit Plan covers Private-Duty Nursing Services when they are performed on an Outpatient basis and when the nurse is not related to the Plan Participant by blood, marriage, or adoption.
2. This Benefit Plan covers Private-Duty Nursing Services subject to the Deductible Amount and Coinsurance shown on the Schedule of Benefits.
3. This Benefit Plan does not pay for Inpatient Private-Duty Nursing Services.
4. This Benefit Plan limits coverage for Private Duty Nursing Services to four hundred (400) hours per Benefit Period.

Z. Sleep Studies

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

AA. Telehealth Services and Remote Patient Therapy Services

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

Interaction between Plan Participant and Provider may take place in different ways, depending on the circumstances, but this interaction must always be suitable for the setting in which the Telehealth Services and Remote Patient Therapy services are provided.

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

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

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

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

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

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

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

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

BB. Temporomandibular Joint Syndrome

Benefits are available to the Plan Participant for the 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 the Schedule of Benefits.

Article 16. CARE MANAGEMENT

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

1. Authorization and Selection of Provider

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

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

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

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

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

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

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

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

a. Admissions

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

b. Outpatient Services, Including Other Covered Services and Supplies

- (1) If a Network Provider or Participating Provider fails to obtain a required Authorization, We may reduce the Allowable Charge by the penalty stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all Outpatient services and supplies requiring an Authorization. The Network Provider or Participating Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Copayment, Deductible Amount and Coinsurance shown on the Schedule of Benefits.
- (2) If a Non-Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty if shown on the Schedule of Benefits. The Plan Participant is responsible for all charges not covered and for any applicable Copayment, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

3. Authorization of Admissions

a. Authorization of Elective Admissions

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

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

b. Authorization of Emergency Admissions

It is the Plan Participant's responsibility to ensure that the Physician or Hospital, or a representative thereof, notifies Our care management department of all Emergency Admissions. Within forty-eight (48) hours of

the Emergency Admission, We must be notified regarding the nature and purpose of the Emergency Admission. The facility or Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the facility or Provider. We may waive or extend this time limitation if We determine that the Plan Participant is unable to timely notify or direct his representative to notify Us of the Emergency Admission. In the event the end of the notification period falls on a holiday or weekend, We must be notified on the next working day.

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

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

c. Concurrent Review

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

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

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

Certain services, supplies, and Prescription Drugs require Our Authorization before a Plan Participant receives the services, supplies, or Prescription Drugs. The Authorizations list is shown on the Plan Participant's Schedule of Benefits. The Plan Participant is responsible for making sure the Provider obtains all required Authorizations before services, supplies, or Prescription Drugs are received. We may need the Plan

Participant's Provider to submit medical or clinical information about the Plan Participant's condition. To obtain prior Authorizations, the Plan Participant's Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider.

- a. If a request for Authorization is denied by Us, the Outpatient services and supplies are not covered.
- b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, We have the right to determine if the services and supplies were Medically Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider.
- c. Additional amounts for which the Plan Participant is responsible because Authorization of Outpatient services and supplies was denied or not requested are considered non-covered and will not accrue to the Out-of-Pocket Amount.

B. Disease Management

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

C. Case Management

1. The Plan Participant may qualify for Case Management Services, at Our discretion, based on various criteria including diagnosis, severity, length of illness, and proposed or received treatment. The Case Management program seeks to identify candidates as early as possible and to work with patients, their Physicians, their families, and other community resources to assess treatment alternatives and available Benefits.
2. The role of Case Management is to service the Plan Participant by assessing, facilitating, planning and advocating for health needs on an individual basis. Many clients benefit from Case Management, including people in an acute phase of illness or with a chronic condition.
3. Our determination that a Plan Participant's medical condition renders the Plan Participant suitable for Case Management services will not obligate Us to make the same or similar determination for any other Plan Participant. Because We provide Case Management services to one Plan Participant, that does not entitle any other Plan Participant to Case Management services and We do not waive Our right to administer and enforce this Benefit Plan according to its express terms.
4. Unless We expressly agree, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and remain in full force and effect if the Plan Participant receives Case Management services.
5. The Plan Participant's Case Management services will end when any of the following occur:
 - a. In Our sole discretion, We determine that the Plan Participant is no longer suitable for the Case Management services or that the Plan Participant no longer needs them.

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

D. Alternative Benefits

1. The Plan Participant may qualify for Alternative Benefits, at Our discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or received treatment. The Alternative Benefits program seeks to identify candidates as early as possible and to work with patients, their Physicians, their families, and other community resources to assess treatment alternatives and available Benefits when We decide it to be beneficial to the Plan Participant and to Us.
2. Our determination that the Plan Participant's medical condition renders the Plan Participant suitable for Alternative Benefits will not obligate Us to make the same or similar determination for any other Plan Participant. Because We provide Alternative Benefits to one Plan Participant, that does not entitle any other Plan Participant to Alternative Benefits, and We do not waive Our right to administer and enforce this Benefit Plan according to its express terms.
3. Unless We expressly agree, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and remain in full force and effect if the Plan Participant receives Alternative Benefits.
4. Alternative Benefits are provided instead of the Benefits to which the Plan Participant is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Benefit Plan.
5. The Plan Participant's Alternative Benefits will end when any of the following occur:
 - a. In Our sole discretion, We determine that the Plan Participant is no longer suitable for the Alternative Benefits or that the Plan Participant no longer needs them.
 - b. The Plan Participant receives care, treatment, services, or supplies that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by Us.

Article 17. LIMITATIONS AND EXCLUSIONS

- A. Benefits for conditions, services, Surgery, supplies and treatment that are not covered under this Benefit Plan are excluded.
- B. If a Plan Participant has Complications from excluded conditions, Surgery, or treatments; Benefits for such conditions, services, Surgery, supplies and treatment are excluded.
- C. Any of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown on the Schedule of Benefits.
- D. Unless otherwise shown as covered on the Schedule of Benefits, the following are excluded:
 1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary, as defined in this Benefit Plan. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be given, does not make it Medically Necessary.
 2. Any charges exceeding the Allowable Charge.
 3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.

4. Benefits are excluded for services, Surgery, supplies, treatment, or expenses:
- a. other than those specifically listed as covered by this Benefit Plan. Benefits are not payable for services a Plan Participant has no obligation to pay, or for which no charge or a lesser charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions;
 - b. rendered or furnished before the Plan Participant's Effective Date or after Plan Participant's coverage terminates, except as follows: Medical Benefits in connection with an Admission will be provided for an Admission in progress on the date a Plan Participant's coverage under this Benefit Plan ends, until the end of that Admission or until a Plan Participant has reached any Benefit limitations set in this Benefit 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 issued by Blue Cross and Blue Shield of Louisiana or any other Blue Cross and Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law, and except for limited benefit policies;
 - e. paid or payable under Medicare Parts A or B when a Plan Participant has Medicare, except when Medicare Secondary Payer provisions apply;
 - f. which are Investigational, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures;
 - g. rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs, including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes whether or not coverage under such laws or programs is actually in force. This exclusion shall not apply to services rendered to a Plan Participant holding ten (10%) percent or more ownership in the Group, if the Plan Participant has done all of the following: (1) legally opted to be excluded from workers' compensation coverage for the Group by entering into a written agreement with the Group's workers' compensation carrier electing not to be covered by such coverage; (2) properly enrolled with the Company in owner 24-hour health coverage; (3) furnished the Company with a copy of the written agreement between the Plan Participant and the workers' compensation carrier; (4) furnished the Company with written evidence of the Plan Participant's ownership interest in the Group. If this information is not submitted to the Company at the time of Plan Participant's initial enrollment for health coverage, or upon acquisition of the required ownership percentage, then the Plan Participant may enroll for this coverage during the Plan Participant's next Open Enrollment period;
 - h. received from a dental, vision, or medical department or clinic maintained by or on behalf of an Employer, a mutual benefit association, labor union, trust, or similar person or group;
 - i. given, prescribed, or otherwise provided by a Provider who is the Plan Participant, the Plan Participant'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 the Plan Participant and the Provider unless specifically stated as covered under the Telehealth Services Benefit; for services billed with Telehealth codes not suitable for the setting in which the services are provided; for Telehealth Services not permitted by Us; and for Telehealth Services rendered by Providers not permitted by Us;
 - k. for Remote Patient Therapy services and devices unless the results are specifically required for a medical treatment decision for a Plan Participant or as required by law;

- l. for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records of information required to adjudicate a Claim, or for access to our enrollment in or with any Provider;
 - m. for services performed in the home unless the services meet the definition of Home Health Care, or otherwise covered specifically in this Benefit Plan, or are approved by Us;
 - n. any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan; or
 - o. for paternity tests and tests performed for legal purposes.
5. Benefits are excluded for services in the following categories:
- a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
 - b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;
 - c. those occurring as a result of taking part in a riot or acts of civil disobedience;
 - d. those occurring as a result of a Plan Participant's commission or attempted commission of a felony;
 - e. for treatment of any Plan Participant detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.
6. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses in connection with or related to, or Complications from the following:
- a. rhinoplasty;
 - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
 - c. gynecomastia;
 - d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Benefit Plan;
 - e. implantation, removal, 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 the Plan Participant's healthcare coverage under this Benefit Plan. We may also offer services as a Value-Added Services subject to minimal additional cost. If clinically eligible to participate, the Plan Participant voluntarily chooses whether to participate in the programs;
 - i. Participation in diabetes prevention programs will be 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 Plan Participants 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/or
 - p. primarily to enhance athletic abilities.
7. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses related to:
- a. routine eye exams (except for those for diabetics shown in the Other Covered Services, Supplies or Equipment Article), 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 Benefit 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 Benefit Plan;
 - d. hair pieces, wigs, hair growth, and hair implants;
 - e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser Surgery; or
 - f. visual therapy.
8. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment or expenses related to:
- a. any costs of donating an organ or tissue for transplant when a Plan Participant is a donor except as provided in this Benefit Plan;
 - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include 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 Benefit Plan; or
 - e. Gene Therapy or Cellular Immunotherapy if prior Authorization is not obtained or if the services are performed at an administering facility that has not been approved in writing by Us prior to services being rendered.

9. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any of the following, except as specifically provided in this Benefit Plan or on 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 CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low-Protein Food Products or prescription donor human breast milk as described in this Benefit Plan.
11. Benefits are excluded for Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered on the Schedule of Benefits:
- a. lifestyle-enhancing drugs including, but not limited to, medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), medications used to enhance athletic performance, medications used for effects of aging on the skin, and medications used for hair loss or restoration (e.g., Propecia®, Rogaine®), except for Prescription Drugs approved by Us to treat alopecia areata or alopecia universalis;
 - b. medications for obesity, weight loss, weight management, or weight maintenance (e.g., Contrave®, Qsymia®, Saxenda®, Wegovy™);
 - c. any 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 two 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. Low Protein Food Products and prescription donor human breast milk are covered as described in this Benefit Plan;
 - g. prescription vitamins not listed as covered in the Prescription Drug Formulary (including but not limited to, Enlyte);
 - h. drugs that can be lawfully obtained without a Physician's order or that do not require a prescription, including over-the-counter (OTC) drugs, except those required to be covered by law;

- i. selected Prescription Drugs for which 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 Benefit Plan, or a refill before seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription;
- k. compounded drugs that exhibit any of the following characteristics:
 - (1) are similar to a commercially available product;
 - (2) whose principal 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 one (1) active ingredient (sometimes called combination drugs);
- m. Prescription Drug products that include or are packaged with a non-Prescription Drug product;
- n. Prescription Drug compounding kits;
- o. selected Prescription Drug products that are packaged in a way that contains more than one (1) Prescription Drug;
- p. selected Prescription Drug products with multiple therapeutic alternatives, which may be available in a greater or lesser strength or different dosage form (e.g., tablet, capsule, liquid, suspension, extended release, tamper resistant);
- q. Prescription Drug products that contain marijuana, including medical marijuana;
- r. Prescription Drugs filled before the Plan Participant's Effective Date or after a Plan Participant's 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 Plan Participants 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 Plan Participant 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 determine 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 the Plan Participant's 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 Plan Participant's Copayment. In that case, the Plan Participant must pay the Prescription Drug cost and sales tax.
12. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for personal comfort, personal hygiene and convenience items including air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to a Plan Participant's home or vehicle.
 13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for palliative or cosmetic care or treatment of the foot; supportive devices of the foot; and treatment of flat feet, except for Medically Necessary Surgery.
 14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for routine foot care. Benefits for a total of six (6) services, treatments, or procedures for cutting or removal of corns and calluses, nail trimming, or debriding are covered. Benefits are limited to a total of six (6) services, treatments, or procedures per Benefit Period whether such services, treatments, or procedures are provided by Network or Non-Network Providers. All other services, treatments, or procedures in excess of this limit are not covered.
 15. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any abortions other than to save the mother's life.
 16. **REGARDLESS OF CLAIM 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, these procedures are not available for Benefits.
 17. **REGARDLESS OF CLAIM 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.

18. **REGARDLESS OF CLAIM 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.
19. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.
20. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Cosmetic Surgery, piercings, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly or Mastectomy. Complications resulting from any of these items, or any other non-covered items are excluded.
21. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for acupuncture when used to provide treatment for a condition or service that is excluded from coverage under this Benefit Plan.
22. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits. This exclusion does not apply to Cleft Lip and Cleft Palate coverage.
23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, hyperplasia or hypoplasia of the mandible or maxilla, and any orthognathic condition, except as required by law. This exclusion does not apply to Cleft Lip and Cleft Palate coverage.
24. **REGARDLESS OF CLAIM 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 Benefit Plan.
25. **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.
26. **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.
27. **REGARDLESS OF CLAIM 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 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.
28. Benefits are excluded for Applied Behavior Analysis that We determine is not Medically Necessary. The following is also excluded: Applied Behavior Analysis rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.
29. **REGARDLESS OF CLAIM 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.

30. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Custodial Care, nursing home care, assisted living facility care or custodial home care, regardless of the level of care required or provided. This exclusion for Custodial Care does not apply to Habilitative Care services that the law requires Us to cover. This exclusion for Custodial Care applies to Claims for Private Duty Nursing Services that are determined by Us to be Custodial Care.
31. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Hospital charges for a well newborn.
32. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.
33. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for medical and Surgical treatment for snoring without obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).
34. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for reversal of a voluntary sterilization procedure.
35. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when We Authorize them.
36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a Plan Participant related to:
 - a. Genetic testing, unless the results are specifically required for a medical treatment decision for the Plan Participant or as the law requires;
 - b. Pre-implantation genetic diagnosis;
 - c. Preconception carrier screening; and
 - d. Prenatal carrier screening except screenings for cystic fibrosis.
37. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services or supplies for the prophylactic storage of cord blood.
38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for sleep studies, unless performed as a home sleep study or in a Network-accredited sleep laboratory. If a sleep study is not performed by a Network-accredited sleep laboratory, as a home sleep study or We deny a sleep study, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.

Article 18. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

If eligibility for Group coverage ends when the Plan Participant dies, a surviving Spouse covered as a Dependent who is fifty (50) years of age or older, has ninety (90) days from the date of the Plan Participant's death to notify Us of election to continue the same coverage for himself, and if already covered, for his Dependent children.

Coverage is automatic during the 90-day election period. Contributions must be paid for this coverage. If continuation is not chosen, or if contributions are not received for the ninety (90) days of automatic coverage, the ninety (90) days of automatic coverage is terminated retroactive to the end of the billing cycle in which the death occurred.

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

The Plan Administrator will be responsible for notifying the Spouse of the right to continue and for billing and collection of contributions towards the cost of coverage. However, if We have been furnished with the home address of the surviving Spouse at the time of death and have been notified by the Group in a manner acceptable to Us of the death of the Plan Participant, We will notify the surviving Spouse of the right to continue.

Coverage continues on a contribution paying basis until the earliest of:

- the date contributions are due and 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 Plan Participant or covered Dependent whose coverage under this Benefit Plan ends because of: 1) The Plan Participant's death; 2) The Plan Participant's termination of active employment; 3) because of the divorce of the Plan Participant, the Plan Participant or Dependents may be entitled to continue the coverage under this Benefit Plan. The Plan Participant or Dependent requesting continuation must have been continuously covered under this Benefit Plan (or another group policy that this Benefit Plan replaced) for the three (3) consecutive months immediately preceding the date this coverage would otherwise have ended.

Continuation of coverage for a Plan Participant or his Dependents is **not** available if:

- the Plan Participant or Dependent, within thirty-one (31) days of termination of coverage, is or could have been covered by other group coverage or a government sponsored health plan such as Medicare or Medicaid, or group; or
- the Plan Participant's or Dependent's coverage under this Benefit Plan terminated due to fraud or failure to pay the required contribution; or
- the Plan Participant or Dependent is eligible for continuation of coverage under COBRA.

To elect continuation of coverage under this section, the Plan Participant or Dependent must notify the Group in writing of election to continue this Group health coverage and must pay any required contribution to the Group in advance. The initial contribution must be paid no later than the end of the month following the month in which the event occurred which made the Plan Participant or Dependent eligible. (If the Dependent is eligible due to divorce, the event shall be deemed to have occurred on the date of the judgment of divorce.) A form to continue coverage is available from the Group.

Continuation of coverage under the Group plan for any Plan Participant or Dependent shall terminate on the earliest of the following dates:

- twelve (12) calendar months from the date coverage would have otherwise ended; or
- the date ending the period for which the Plan Participant or Dependent makes his last required contribution for the coverage; or
- the date the Plan Participant or Dependent 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 plan is terminated; or
- the date on which an enrolled Plan Participant of a health maintenance organization legally resides outside the service area of the Network.

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

Do I have other alternatives to COBRA continuation coverage?

COBRA continuation coverage is not the only alternative Plan Participants may have when they lose coverage under this Benefit Plan. 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 sixty (60) days from when You lose coverage under this Benefit Plan to apply for special enrollment through the Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special enrollment opportunity for the Marketplace, and You will not be able to enroll until the Marketplace's normal enrollment period opens or Your COBRA continuation coverage is exhausted.

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 thirty (30) days from losing coverage under this Benefit 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 Plan Participant;
- divorce or legal separation between a covered Plan Participant and their Spouse;
- the Plan Participant 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 Benefit 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 thirty-six (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 health plan to any Employees or the qualified beneficiaries fail to pay the required premiums or become covered under another Employer's group health plan that does not exclude or limit Benefits for a qualified beneficiary's Pre-Existing Conditions. COBRA continuation coverage rights under Chapter 11 bankruptcy proceedings will be 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 sixty (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 a Plan Participant would otherwise lose coverage under the Group health plan (the coverage end date); and
- ends sixty (60) days after the coverage end date or sixty (60) days after the Plan Participant is notified of their right to continue coverage, whichever is the latest.

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

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

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

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

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

- eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the Employee became entitled to Medicare benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified beneficiaries other than the Employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or
- thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or
- the date the Employer ceases to maintain any Group health plan for its Employees; or
- the date coverage ceases because of nonpayment of required premiums when due; or
- the date the qualified beneficiary first becomes covered under another group health plan and Benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (Note: There are limitations on plans imposing Pre-Existing Condition exclusions and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act); or
- the date the qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

Can I extend my COBRA continuation coverage?

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

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

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

- the Employee or former Employee dies;
- the Employee or former Employee becomes entitled to Medicare (under Part A, Part B, or both);
- the Employee or former Employee and Dependent Spouse divorce;
- the Dependent child is no longer eligible under the Benefit Plan as a Dependent.

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

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

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

The qualified beneficiary must also notify the Group within thirty (30) days of any final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. In this case, coverage will end the earliest of twenty-nine (29) months after the date of the qualifying event or the first day of the month that begins more than thirty (30) days after a final determination that the qualified beneficiary is no longer disabled, subject to the original eighteen (18) months of COBRA coverage.

Keep Your Plan Informed of Address Changes

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

D. Employee Rights Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

Employees going on a military leave of absence to perform service in the United States uniformed services (as that term is defined under USERRA) may choose to continue coverage under this Benefit Plan for up to twenty-four (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 Benefit Plan immediately before they left for military service. Dependents cannot independently choose USERRA continuation coverage.

To claim USERRA continuation coverage, Employees must properly notify the Employer that they are leaving to perform service in the uniformed services and apply for continuation coverage as required by the Employer.

Employees who choose USERRA continuation coverage may be required to pay contributions. If the leave of absence lasts thirty (30) days or less, the Employee may have to pay the required contribution for coverage. However, if the military leave of absence lasts more than thirty (30) days, the Employee may have to pay up to 102% of the full contribution under the Benefit Plan (including both, the Employer's and the Employee's contribution for coverage).

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

- The Employee fails to pay the required contributions on time, or
- The day after the date on which the law requires the Employee to apply for or return to a position of employment and fails to do so.

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

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

Article 19. COORDINATION OF BENEFITS

A. Applicability

This section applies when a Plan Participant has healthcare coverage under more than one Plan. Plan is defined below.

The Order of Benefit Determination Rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its terms of coverage without concern of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed one hundred percent (100%) of the total Allowable Expense.

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

1. Allowable Expense – Healthcare services or expenses, including deductible, coinsurance or copayments, that are covered in full or in part by any Plan covering a Plan Participant. The following are examples of services or expenses that are and are not Allowable Expenses:
 - a. A healthcare service or expense or a portion of a service or expense that is not covered by any of the Plans covering a Plan Participant is not an Allowable Expense.
 - b. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.
 - c. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
 - d. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.
 - e. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - f. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable Expense for all Plans.

- g. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, prior authorization of admissions, and preferred provider arrangements.
2. Closed Panel Plan – A Plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
3. Coordination of Benefits or COB – A provision establishing an order in which Plans pay their claims and permitting Secondary Plans to reduce their benefits so that the combined benefits of all Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. The COB provision applies to the part of the Benefit Plan providing healthcare Benefits which may be reduced because of the benefits of other Plans.

Any other part of the Benefit Plan providing healthcare Benefits is separate from this Benefit Plan. This Benefit Plan may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits.

4. Custodial Parent –
 - a. the parent awarded custody of a covered child by a court decree; or
 - b. in the absence of a court decree, the parent with whom the covered child resides more than one half of the calendar year without regard to any temporary visitation.
5. Order of Benefit Determination Rules – Rules that determine whether this Benefit Plan is a Primary Plan or Secondary Plan when a Plan Participant has healthcare coverage under more than one Plan. When this Benefit Plan is Primary, We determine payment for Benefits first before those of any other Plan and without considering any other Plan's benefits. When this Benefit Plan is Secondary, We determine Benefits after those of another Plan and may reduce the Benefits We pay so that all Plan benefits do not exceed one hundred percent (100%) of the total Allowable Expense.
6. Plan – Any of the following that provide benefits or services for medical or dental care or treatment. If separate Plans or contracts are used to provide coordinated coverage for members of a group, the separate Plans or contracts are considered parts of the same Plan and there is no COB among those separate Plans or contracts.
 - a. Plan includes:
 - (1) group and non-group insurance contracts;
 - (2) health maintenance organization (HMO) contracts;
 - (3) group or group-type coverage through Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured);
 - (4) the medical care components of long-term care contracts, such as skilled nursing care;
 - (5) the medical benefits in group or individual automobile no fault and traditional automobile or fault contracts; and
 - (6) Medicare or any other governmental benefits, as permitted by law.
 - b. Plan does not include:
 - (1) hospital indemnity coverage benefits or other fixed indemnity coverage;
 - (2) accident only coverage;

- (3) specified disease or specified accident coverage;
- (4) limited benefit health coverage as defined by state law;
- (5) school accident-type coverage except those enumerated in La.R.S. 22:1000 (A)(3)(C);
- (6) benefits for non-medical components of long-term care contracts;
- (7) Medicare supplement policies;
- (8) Medicaid plans; or
- (9) coverage under other government Plans, unless permitted by law.

Each contract for coverage under 6(a) or (b), above, is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- 7. Primary Plan – A Plan whose benefits for a covered person’s healthcare coverage must be determined without taking the existence of any other Plan into consideration.
- 8. Secondary Plan – A Plan that is not a Primary Plan and determines its benefits after the Primary Plan pays benefits.

C. Coordination of Benefits and Order of Benefit Determinations

- 1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:
 - a. The Primary Plan pays or provides its benefits according to its terms of coverage and without concern of the benefits under any other Plan.
 - b. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan will pay or provide benefits as if it were the Primary Plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the Closed Panel Plan.
 - c. When multiple contracts providing coordinated coverage are treated as a single Plan under the Louisiana Department of Insurance (LDI) Regulation 32, then this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the Plan, the issuer designated as Primary within the Plan will be responsible for the Plan’s compliance with LDI Regulation 32.
 - d. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination Rules of LDI Regulation 32 decide the order in which Secondary Plans benefits are determined in relation to each other. Each Secondary Plan must take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan, which, under LDI Regulation 32, has benefits determined before those of that Secondary Plan.
 - e. Except as provided in (f) below, a Plan that does not contain a Coordination of Benefits provision that is consistent with Regulation 32 is always Primary unless the provisions of both Plans state that the complying Plan is Primary.
 - f. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

2. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is the Secondary Plan.
3. Order of Benefit Determination

Each Plan determines its order of benefits using the first of the following provisions that apply.

a. Non-Dependent or Dependent Provision

The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a dependent; and Primary to the Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed. The Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

b. Dependent Child Covered Under More Than One Plan Provision

Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows.

- (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (a) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (b) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
- (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This provision applies to plan years commencing after the Plan is given notice of the court decree;
 - (b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of subparagraph (3)(b)(1), above will determine the order of benefits;
 - (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of subparagraph (3)(b)(1), above, will determine the order of benefits; or
 - (d) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - (i) The Plan covering the Custodial Parent;
 - (ii) The Plan covering the spouse of the Custodial Parent;
 - (iii) The Plan covering the non-Custodial Parent; and then
 - (iv) The Plan covering the spouse of the non-Custodial Parent.

(3) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraphs (3)(b)(1) or (3)(b)(2), above, shall determine the order of benefits as if those individuals were the parents of the child.

(4) For a dependent child covered under the spouse's Plan:

(a) For a dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a dependent under a spouse's Plan, the Longer or Shorter Length of Coverage Provision, below, applies.

(b) In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits will be determined by applying the birthday provision above in subparagraph (3)(b)(1) to the dependent child's parent(s) and the dependent's spouse.

c. Active Employee or Retired or Laid-off Employee Provision

The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this provision, and as a result, the Plans do not agree on the order of benefits, this provision is ignored. This provision does not apply if the Non-Dependent or Dependent Provision, above, can determine the order of benefits.

d. COBRA or State Continuation Coverage Provision

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this provision, and as a result, the Plans do not agree on the order of benefits, this provision is ignored. This provision does not apply if the Non-Dependent or Dependent Provision, above, can determine the order of benefits.

e. Longer or Shorter Length of Coverage Provision

The Plan that covered the person as an employee, member, policyholder, subscriber or retiree for a longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

f. Fall-Back Provision

If none of the preceding provisions determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, this Benefit Plan will never pay more than We would have paid had We been the Primary Plan.

D. Effects on the Benefits of this Benefit Plan

1. When this Benefit Plan is Secondary, We may reduce Benefits so that the total Benefits paid or provided by all Plans during a plan year are not more than one hundred percent (100%) of the total Allowable Expenses. In determining the amount to be paid for any Claim, as the Secondary Plan, We will calculate the benefits We would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under Our Benefit Plan that is unpaid by the Primary Plan. As the Secondary Plan, We may then reduce Our payment by the amount so that, when combined with the amount paid by the Primary Plan, the total Benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, as the Secondary Plan, We will credit to the Benefit Plan Deductible Amount any amounts We would

have credited to the Deductible Amount in the absence of other healthcare coverage. In any event, this Benefit Plan will never pay more than We would have paid had We been the Primary Plan.

2. The difference between the Benefit payments that We would have paid had We been the Primary Plan, and the Benefit payments that We actually paid or provided shall be recorded as a benefit reserve for You or a covered family member and used by Us to pay any Allowable Expenses, not otherwise paid during the plan year. As each Claim is submitted, We will:
 - a. determine Our obligation to pay or provide Benefits under the Benefit Plan;
 - b. determine whether a benefit reserve has been recorded for You and Your covered family member; and
 - c. determine whether there are any unpaid Allowable Expenses during the plan year.
3. If there is a benefit reserve, as the Secondary Plan, We will use You and Your covered family member's benefit reserve to pay up to one hundred percent (100%) of total Allowable Expenses incurred during the plan year. At the end of the plan year, the benefit reserve returns to zero. A new benefit reserve must be created for each new plan year.
4. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB will not apply between that Plan and other Closed Panel Plans.

You may request a copy in either paper form or electronic form of LDI Regulation 32 - Appendix C, which provides an explanation for Secondary Plans on the purpose and use of the benefit reserve and how Secondary Plans calculate claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at https://www.lidi.la.gov/docs/default-source/documents/legaldocs/regulations/reg32-appendixc.pdf?sfvrsn=24e14b52_0.

E. Summary

This is a summary of only a few of the provisions of Your Benefit Plan to help You understand Coordination of Benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language above, which determines Your Benefits.

1. Double Coverage

It is common for family members to be covered by more than one healthcare Plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. When You are covered by more than one healthcare Plan, state law permits Your insurers to follow a procedure called Coordination of Benefits to determine how much each should pay when You have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than Your covered healthcare expenses. Coordination of Benefits is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

2. Primary or Secondary

You will be asked to identify all the Plans that cover members of Your family. We need this information to determine whether We are the Primary or Secondary benefit payer. The Primary Plan always pays first when You have a claim. Any Plan that does not contain Your state's COB rules will always be Primary.

3. When this Benefit Plan is Primary

If You or a family member are covered under another Plan in addition to this one, We will be Primary when:

- a. The Claim is for Your own healthcare expenses, unless You are covered by Medicare and both You and Your Spouse are retired;

- b. The Claim is for Your Spouse's healthcare expenses, who is covered by Medicare, and You are not both retired;
- c. The Claim is for the healthcare expenses of Your child who is covered by this Benefit Plan and:
 - (1) You are married and Your birthday is earlier in the year than Your Spouse's or You are living with another individual, regardless of whether or not You have ever been married to that individual, and Your birthday is earlier than that other individual's birthday. This is known as the birthday provision;
 - (2) You are separated or divorced, and You have informed Us of a court decree that makes You responsible for Your Dependent child's healthcare expenses; or
 - (3) There is no court decree, but You have custody of Your Dependent child.

4. Other Situations

- a. We will be Primary when any other provisions of state or federal law require Us to be. When We are the Primary Plan, We will pay the Benefits in accordance with the terms of Your Benefit Plan, just as if You had no other healthcare coverage under any other Plan.
- b. We will be Secondary whenever the rules do not require Us to be Primary. When We are the Secondary Plan, We do not pay until after the Primary Plan has paid its benefits. We will then pay part, or all of the Allowable Expenses left unpaid, as explained below. An Allowable Expense is a healthcare service or expense covered by one of the Plans, including Copayments, Coinsurance and Deductible Amounts.
 - (1) If there is a difference between the amount the Plans allow, We will base Our payment on the higher amount. However, if the Primary Plan has a contract with the provider, Our combined payments will not be more than the provider contract calls for. Health maintenance organizations and preferred provider organizations usually have contracts with their providers.
 - (2) We will determine Our payment by subtracting the amount the Primary Plan paid from the amount We would have paid if We had been Primary. We will use any savings to pay the balance of any unpaid Allowable Expenses covered by either Plan.
 - (3) If the Primary Plan covers similar kinds of healthcare expenses, but allows expenses that We do not cover, We will pay for those items as long as there is a balance in Your benefit reserve, as explained below.
 - (4) We will not pay an amount the Primary Plan did not cover because You did not follow its rules and procedures. For example, if the Plan has reduced its benefit because You did not obtain prior authorization, as required by that Plan, We will not pay the amount of the reduction, because it is not an Allowable Expense.

c. Benefit Reserve

When We are Secondary We often will pay less than We would have paid if We had been Primary. Each time We save by paying less, We will put that savings into a benefit reserve. Each family member covered by this Benefit Plan has a separate benefit reserve. We use the benefit reserve to pay Allowable Expenses that are covered only partially by both Plans. To obtain a reimbursement, You must show Us what the Primary Plan has paid so We can calculate the savings. To make sure You receive the full Benefit or coordination, You should submit all Claims to each of Your Plans. Savings can build up in Your reserve for one plan year. At the end of the plan year any balance is erased. A new benefit reserve begins for each covered person the next year as soon as there are savings on Claims.

F. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person for the purpose of determining COB. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Benefit Plan must give Us any facts We need to pay the Claim.

G. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Benefit Plan. We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under this Benefit Plan. To the extent, such payments are made, they discharge Us from further liability. The term payment made includes providing Benefits in the form of services, in which case the payment made will be the reasonable cash value of any Benefits provided in the form of services.

H. Right of Recovery

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

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. other organizations.

The amount of the payments made includes the reasonable cash value of any Benefits provided in the form of services.

Article 20. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

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

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

A. The Benefit Plan

1. This Benefit Plan, including the Group's acceptance of Our proposal, Application, Enrollment Forms, Benefit change forms and renewal forms and documentation, expressing the entire money and other consideration for coverage, the Schedule of Benefits, and any amendments or endorsements, constitutes the entire contract between the parties.
2. Except as specifically provided herein, this Benefit Plan will not make Us liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Group will be the administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those specifically undertaken by Us herein. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Plan Participant for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or for Emergency Medical Services. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold Us harmless in the event We incur any liability as a result of the Group's failure to 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 thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.
4. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.
5. The Plan Administrator shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.
6. We shall have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third-parties relative to this Benefit Plan. Any of the functions to be performed by Us under this Benefit Plan may be performed by Us or any of Our subsidiaries, affiliates, subcontractors, or designees.

B. Section 1557 Grievance Procedure

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

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

If You believe You have been 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 one hundred eighty (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:

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

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

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

D. Identification Cards and Benefit Plans

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

E. Benefits to Which Plan Participants Are Entitled

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Benefit Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.
2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.
3. Continuity of healthcare services.
 - a. When We end a contractual agreement with a Provider, if the Plan Participant has begun a course of treatment with that Provider, We will notify the Plan Participant that We have removed the Provider from the Preferred Care PPO Network. If the Plan Participant is a continuing care patient, the Plan Participant can continue receiving Covered Services until the earlier of the completion of the course of treatment or ninety (90) days after We notify the Plan Participant 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) The Plan Participant voluntarily chooses to change Providers.
- (4) The Plan Participant moves outside of the geographic service area of the Provider or the Preferred Care PPO Network.
- (5) The Plan Participant's condition does not meet the requirements to be deemed a Serious and Complex Condition.

F. Termination of a Plan Participant's Coverage

1. We may choose to rescind coverage or terminate a Plan Participant's coverage if the Plan Participant commits fraud or intentionally misrepresents material facts under the terms of this Benefit 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 or covered Plan Participant or Dependent, intentionally misrepresents material fact. Coverage may be rescinded retroactively to the Effective Date of coverage or terminated within three (3) years of the Effective Date, for fraud or intentional misrepresentation of material fact. We will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If the Plan Participant enrolls someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.
2. Unless continuation of coverage is available and selected as provided in this Benefit Plan, coverage terminates as provided below:
 - a. The Plan Participant's coverage and that of all his Dependents automatically, and without notice, terminates on the date of termination.
 - b. The coverage of the Plan Participant's Spouse will terminate automatically, and without notice, on the date of a final decree of divorce or other legal termination of marriage.
 - c. 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 contributions have been paid through that period.
 - d. Upon the death of a Plan Participant, the coverage of all of surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if contributions have been paid through that period. However, a surviving Spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.
3. If the Group cancels this Benefit Plan, such cancellation or termination alone will operate to end all rights to Benefits under of this Benefit Plan as of the Effective Date of such cancellation or termination. The Group must notify its Plan Participants and beneficiaries of such cancellation or termination. We do not have to notify You.
4. Except as may be otherwise provided in this Benefit Plan, no Benefits are available to a Plan Participant for Covered Services rendered after the date of cancellation or termination of coverage.
5. When no more children or grandchildren are covered under this Benefit Plan, We can automatically change the Plan Participant's class of coverage.

G. Filing Claims

1. The Plan Participant must file all Claims within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than fifteen (15) months from the date services were rendered.
2. Most Plan Participants that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Plan Participant. However, if the Plan

Participant must file a Claim to access the Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form.

Plan Participants may obtain the Prescription Drug Claim Form by accessing the pharmacy section of Our website, www.bcbsla.com/pharmacy. The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Our Pharmacy Benefit Manager, whose telephone number is found on the ID card.

H. Applicable Law and Conforming Policy

This Benefit Plan is governed and construed according to the laws and regulations of the State of Louisiana except when preempted by federal law. This Benefit Plan is not subject to regulation by any other state. If any provision of this Benefit Plan conflicts with any law of the State of Louisiana or the United States of America, the Benefit Plan will be automatically amended to meet the minimum requirements of the law. Any legal action filed against the Benefit Plan must be filed in the appropriate court in the State of Louisiana.

I. Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.
2. Any and all lawsuits, other than those related to Claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

J. Release of Information

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

K. Assignment

1. A Plan Participant's rights and Benefits under this Benefit Plan are personal to the Plan Participant and may not be assigned in whole or in part by the Plan Participant. We will recognize assignments of Benefits to Hospitals if both this Benefit Plan and the Provider are subject to La. R.S. 40:2010. If both 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 a Plan Participant may be liable to for 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 the Plan Participant.

L. Plan Participant and Provider Relationship

1. The choice of a Provider is solely the Plan Participant's.
2. Blue Cross and Blue Shield of Louisiana and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. We do not render Covered Services, but only make payments for Covered Services that the Plan Participant receives. We will not be held liable for any act or omission of any Provider, or for any Claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any Provider or in any Provider's facilities. We have no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.
3. The use or non-use of an adjective such as Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

M. This Benefit Plan and Medicare

1. For Employers with twenty (20) or more active Employees, federal law and regulations require that each active Employee and each active Employee's Spouse, who are both age sixty-five (65) or older, may choose to have coverage under this Benefit Plan or under Medicare.
 - a. If those Employees or Spouses choose coverage under this Benefit Plan, it will be the primary payor of Benefits. The Medicare program will be the secondary payor.
 - b. This Benefit 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 sixty-five (65) or an active Employee's Dependent under age sixty-five (65) is covered under a Group Benefit Plan of an Employer with one hundred (100) or more Employees and also has coverage under Medicare because of Social Security disability, this Benefit Plan is the primary payor and Medicare is the secondary payor.
3. If a Plan Participant is younger than sixty-five (65), covered under this Benefit Plan, and also covered under Medicare only by reason of end-stage renal disease, Medicare will be the primary payor. This Benefit Plan will be the secondary payor, except during the first 30-month period that a Plan Participant is eligible for Medicare benefits only because of end-stage renal disease, this Benefit Plan will be the primary payor and Medicare the secondary payor.
4. When this Benefit Plan is the primary payor, it will pay regular Benefits for Covered Services. When this Benefit 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.

N. Notice

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

O. Job-Related Injury or Illness

The Group must report to the appropriate federal or state governmental agency any job-related injury or illness of a Plan Participant where so required under the provisions of any federal or state laws and/or related programs. This Benefit Plan excludes Benefits for any services rendered as a result of occupational disease or injury compensable under any federal or state workers compensation laws and/or any related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes. In the event that 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 Plan Participant, with any person entitled to receive settlement when the Plan Participant dies, or if the Plan Participant's injury or illness is found to be compensable under federal or state workers compensation laws or programs, the Group or the Plan Participant must reimburse 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.

P. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Group will be subrogated and will succeed to the right of the Plan Participant for the recovery of the amount paid under

this Benefit Plan against any person, organization or other carrier, even where such carrier provides Benefits directly to a Plan Participant who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgement of such subrogation rights. The Group's right to recover will be subordinate to the Plan Participant's right to be "made whole." The Group will pay its proportionate share of the reasonable attorney fees and costs actually incurred by the Plan Participant in pursuing recovery.

2. The Plan Participant will reimburse the Group 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 Benefit Plan. The Group's right to reimbursement will be subordinate to the Plan Participant's right to be "made whole." The Group agrees that it will be responsible for its proportionate share of the reasonable attorney fees and costs actually paid by a Plan Participant in pursuing recovery.
3. The Plan Participant will take such action, give such information and assistance, and execute such papers as may be required to help enforce the Group's rights, and will take no action prejudicing the rights and interest of the Group under this Benefit Plan. We and Our designees have the right to obtain and review the Plan Participant's medical and billing records, if We determine in Our sole discretion, that such records would help pursue the right of subrogation or reimbursement. Nothing in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits Article of this Benefit Plan.
4. The Plan Participant must notify Us of any Accidental Injury.

Q. Right of Recovery

Whenever We have paid for more than the maximum Benefits available for Covered Services under this Benefit 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 the Plan Participant or the Provider, if appropriate. As an alternative, We can deduct from any pending Claim any amounts that the Plan Participant or Provider owes Us.

R. 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 from Us if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

The United States will have the right to collect from Us the reasonable cost of healthcare services incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that the retiree or Dependent would be eligible to receive reimbursement or indemnification from Us if the retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

S. Liability of Plan Affiliates

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

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

T. Out-of-Area Services

Blue Cross and Blue Shield of Louisiana has a variety of relationships with other Blue Cross and/or Blue Shield plans and their Licensed Controlled Affiliates (Licensees). Generally, these relationships are called Inter-Plan Arrangements. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever the Plan Participant obtains healthcare services outside the geographic area We serve, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

1. BlueCard® Program

Under the BlueCard® Program, when the Plan Participant receives Covered Services in the geographic area that a Host Blue serves, We will do what We agreed to do in the plan. However, the Host Blue must contract with and generally handle all interactions with its Participating Providers.

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

- the billed charges for the Plan Participant's Covered Services;
- the negotiated price that the Host Blue makes available to Us; or
- an amount determined by applicable law.

Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare Provider or Provider group that may include types of settlements, incentive payments, and 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 the Plan Participant's Claim because We will not apply them after a Claim has already been paid.

2. Special Case: Value-Based Programs

a. BlueCard® Program

If the Plan Participant receives Covered Services under a Value-Based Program inside a Host Blue's service area, the Plan Participant will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

b. Negotiated (non- BlueCard® Program) Arrangements

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

3. Inter-Plan Programs: Federal 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 the Plan Participant.

4. Non-Participating Providers Outside Our Service Area

a. Plan Participant Liability Calculation

When Covered Services are provided outside of Our service area by Non-Participating Providers, the amount the Plan Participant pays for such services will normally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Plan Participant may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, may govern payments for 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 We would make if the healthcare services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, the Plan Participant may be liable for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this Benefit Plan.

5. Blue Cross Blue Shield Global® Core

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

For medical assistance services (including finding a doctor or Hospital) outside the BlueCard® service area, call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, twenty-four (24) hours a day, seven (7) days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary. Working with a medical professional, an assistance coordinator will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if the Plan Participant contacts the Blue Cross Blue Shield Global® Core service center for assistance, Hospitals will not require the Plan Participant to pay for covered Inpatient services, except for the Deductible Amount and Coinsurance. In such cases, the Hospital will submit Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if the Plan Participant paid in full at the time of service, the Plan Participant must submit a Claim to receive reimbursement for Covered

Services. The Plan Participant must contact Us to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

b. Outpatient Services

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

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

When the Plan Participant pays for Covered Services outside the BlueCard® service area, the Plan Participant must submit a Claim to obtain reimbursement. For institutional and professional Claims, the Plan Participant should complete a Blue Cross Blue Shield Global® Core Claim form and send the Claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of the Claim. The Claim form is available from Us, the Blue Cross Blue Shield Global® Core service center, or online at www.bcbsglobalcore.com. If the Plan Participant needs assistance with Claim submission, call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, twenty-four (24) hours a day, seven (7) days a week.

U. HIPAA Certificates of Creditable Coverage

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

V. Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage

The Medicare Modernization Act (MMA) requires groups whose policies include Prescription Drug coverage to notify Medicare-eligible Plan Participants whether their Prescription Drug coverage is creditable, which is defined to mean that the coverage is expected to pay on average as much as the standard Medicare Part D Prescription Drug coverage. The types of coverage required to provide the notices are those listed at 42 CFR 423.56(b) and includes, but is not limited to, group health plans (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 Plan Participants annually who are covered under its Prescription Drug plan, prior to October 15th each year and at various times as stated in the regulations, including to a Medicare-eligible Plan Participant when they join the Plan. This disclosure must be provided to Medicare-eligible active working Plan Participants and their Dependents, Medicare-eligible COBRA Plan Participants and their Dependents, Medicare-eligible disabled Plan Participants covered under its Prescription Drug plan and any Retirees and their Dependents. The MMA imposes a late enrollment penalty on Plan Participants who do not maintain creditable coverage for a period of sixty-three (63) days or longer following their initial enrollment period for the Medicare Prescription Drug Benefit. Accordingly, this information is essential to a Plan Participant's decision whether to enroll in a Medicare Part D Prescription Drug plan.

Groups are responsible for sending the required notices. As a service to the Group and based upon enrollment data provided to Us by the Group, We shall provide, without charge, Medicare Part D Certificates of Creditable or non-Creditable Prescription Drug Coverage to Medicare-eligible Plan Participants who have Prescription Drug coverage under this Benefit Plan at the following times, or as otherwise directed by law:

- a. 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 sixty (60) days from the beginning of a Plan Year (contract year, renewal year), within thirty (30) days after termination of a Prescription Drug Plan, or within thirty (30) days after any change in creditable coverage status. This requirement does not pertain to the Medicare beneficiaries for whom groups are receiving the Retiree Drug Subsidy (RDS).

Groups are responsible for the submission of the *Online Disclosure to CMS Form*.

W. Continued Coverage During a Leave of Absence

1. Family Medical Leave

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

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

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

We will continue coverage for the Employee during any leave of absence the Group is required to provide by applicable federal or state law, including 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 eligibility criteria under the laws continue to be met. If the Employee's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, the Employee is entitled to re-enroll for coverage. If the Employee is not restored to active full-time employment by the end of the leave of absence period, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in Termination of a Plan Participant's Coverage section of this Benefit Plan.

2. Other Employer-Approved Leave of Absence

When an Employee has been granted a documented, approved leave of absence by the Employer, We will maintain coverage for the Employee and any covered Dependents for a period not to exceed ninety (90) days. The Employee must remain a bona fide Employee of the Group during the approved leave period. The Employer will provide Us with proof of the documented leave, upon request. If the Employer terminates the Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in Termination of a Plan Participant's Coverage section of this Benefit Plan.

X. Compliance with HIPAA Privacy Standards

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

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

1. General

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

2. Permitted Uses and Disclosures

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

3. Authorized Employees

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

- a. **Updates Required.** The Employer shall amend the plan promptly with respect to any changes in the Employees of its workforce who are authorized to receive Protected Health Information.
- b. **Use and Disclosure Restricted.** An authorized Employee of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.
- c. **Resolution of Issues of Noncompliance.** In the event that any Employee of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:
 - (1) investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;

- (3) mitigating any harm caused by the breach, to the extent practicable; and
- (4) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Employer

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

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

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

Y. Compliance with HIPAA Electronic Security Standards

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

- 1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. Electronic Protected Health

Information shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections (3) Authorized Employees and (4) Certification of Employers described above in this section.

Z. Value-Added Services

We may from time to time provide Value-Added Services to the Plan Administrator. These Value-Added Services may be provided to the Plan Administrator directly by Us, or indirectly by an affiliated life, health or disability insurance company, or by a third-party company. Value-Added Services are not considered Benefits under this Plan or any other policy of insurance. The Plan Administrator is never under any obligation to accept Value-Added Services and We may cease offering and paying for Value-Added Services at any time.

AA. 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 Plan Participants and/or policyholders to participate in quality programs;
2. Ensuring Plan Participants and/or policyholders are better able to afford benefits packages;
3. Reducing and alleviating social determinants of health;
4. Reducing transition costs for Plan Participants and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;
5. Rewarding Plan Participants and/or policyholders for choosing lower cost, quality healthcare providers;
6. Rewarding Plan Participants and/or policyholders for selecting lower cost, quality healthcare goods and products;
7. Rewarding Plan Participants and/or policyholders for utilizing digital and other paperless forms of communication of information, including but not limited to plan documents and materials; and
8. Reducing enrollment, technology, or administration costs of Plan Participants and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

Article 21. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Plan Participant is dissatisfied about the care or services they receive from Us or one of Our Providers. Plan Participants may register a Complaint or file a formal written Grievance about Us or a Provider by following the procedures outlined below.

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

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

We have an Expedited Appeals process for situations where the time frame of the standard medical Appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function.

A. Complaint, Grievance, and Informal Reconsideration Procedures

A quality of service concern addresses 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 Plan Participant.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Plan Participants may call customer service to register a Complaint. We will attempt to resolve a Plan Participant'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 Plan Participant does not feel his Complaint was adequately resolved or he wishes to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, the Plan Participant may call 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 Plan Participant within thirty (30) business days of receipt of the Plan Participant's written Grievance.

3. Informal Reconsideration

An Informal Reconsideration is a request by telephone, made by an authorized Provider on the Plan Participant'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.

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

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

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

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

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

The Plan Participant has the right to appoint an authorized representative to represent him in his Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent him in an internal or external review of an Adverse Benefit Determination. The authorized representative may be the Plan Participant's treating Provider if the Plan Participant appoints the Provider in writing.

1. Administrative Appeals

Administrative Appeals involve contractual issues, Rescissions, and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment that is determined to be experimental or Investigational.

All administrative Appeals should be submitted in writing to:

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

a. First Level Administrative Appeals

If a Plan Participant is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination for first level administrative Appeals. Requests submitted to Us after one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination will not be considered.

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

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

b. Second Level Administrative Appeals

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

An Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level Appeals. The Committee's decision is final and binding.

The Committee's decision will be mailed to the Plan Participant, his authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within five (5) days of the Committee meeting.

2. Medical Appeals

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

All medical Appeals should be submitted in writing to:

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

a. First Level Medical Appeals (Internal)

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

Requests submitted to Us after one hundred eighty (180) days of the initial Adverse Benefit Determination will not be considered.

A Physician or other healthcare professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, We will reprocess the Plan Participant's Claim, if any. If the internal medical Appeal is upheld, We will inform the Plan Participant of their right to begin the second level Appeal process.

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

b. Second Level Medical Appeals (External)

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

Requests submitted to Us after four (4) months of receipt of the internal Appeal decision will not be considered. The Plan Participant is required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. **Appeals submitted by Your Provider will not be accepted without this form completed with Your signature.**

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

The IRO decision is considered final and binding.

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

C. Expedited Appeals

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

An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare for a Plan Participant currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the covered person's treating Physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Expedited Appeals are not provided for review of services previously rendered.

An Expedited Appeal is available to, and may be initiated by the Plan Participant, the Plan Participant's authorized representative, or a Provider authorized to act on the Plan Participant's behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

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

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 internal medical Appeal request that meets the criteria for an Expedited Appeal.

In any case where the Expedited internal medical Appeal process does not resolve a difference of opinion between Us and the Plan Participant or the Provider acting on behalf of the Plan Participant, the Appeal may be elevated to an Expedited External Appeal.

If an Expedited internal medical Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process and timeframe.

2. Expedited External Medical Appeal

An Expedited External medical Appeal is a request for immediate review, by an Independent Review Organization. The request may be simultaneously filed with a request for an Expedited internal medical Appeal, since the IRO assigned to conduct the Expedited External medical review will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for Expedited External medical Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

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

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

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

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

We will provide the Plan Participant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the determination that is the subject of the NSA appeal.

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

1. NSA Internal Appeals

If a Plan Participant believes that We have not complied with the surprise billing and cost-sharing protections or with continuity of care of the NSA, a written request for review must be submitted within one hundred eighty (180) days of the NSA-related Adverse Benefit Determination. Requests submitted to Us after one hundred eighty (180) days of the NSA-related Adverse Benefit Determination will not be considered.

The NSA internal Appeals request should be submitted in writing to:

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

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

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

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

2. NSA External Appeals

If a Plan Participant disagrees with the NSA internal Appeal decision, a written request for an NSA External Appeal must be submitted within four (4) months of receipt of the NSA internal Appeal decision. Requests submitted to Us after four (4) months of receipt of the NSA internal Appeal decision will not be considered.

You are required to sign and return the form included in the NSA internal Appeal denial notice which authorizes release of medical records for review by the IRO. Appeals submitted by Your Provider will not be accepted without this form completed with Your signature.

The NSA External Appeals request should be submitted in writing to:

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

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

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

We will provide the IRO all pertinent information necessary to conduct the NSA External Appeal. The external review will be completed within forty-five (45) days of Our receipt of the request for an NSA External Appeal. The IRO will notify the Plan Participant, his authorized representative, or a Provider authorized to act on the Plan Participant's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Plan Participant and Us for purposes of determining coverage under this Benefit Plan. This NSA External Appeal process shall constitute the Plan Participant's sole recourse in disputes concerning whether We complied with the surprise billing and cost-sharing protections of the NSA, except to the extent that other remedies are available under state or federal law.

The Plan Participant may contact 1-800-985-3059 or visit www.cms.gov/nosurprises for more information about Plan Participant rights under the NSA.

Article 22. ERISA RIGHTS

To the extent this is an ERISA plan, the Plan Participant is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For 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. Receive Information About the Plan and Benefits

1. A Plan Participant may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents 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. Upon written request to the Plan Administrator, a Plan Participant may obtain copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. A Plan Participant may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.
4. A complete list of Employers or Employee organizations sponsoring the Plan may be obtained by Plan Participants and beneficiaries upon written request to the Plan Administrator and is available for examination by Plan Participants and beneficiaries, as required by §§2520.104b-1 and §§2540.104b.

B. Continue Group Health Plan Coverage

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

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate the plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of the Plan Participant and other beneficiaries. No one, including his Employer, union or any other person, may fire him or otherwise discriminate against him in any way to prevent him from obtaining a plan Benefit or exercising his rights under ERISA.

D. Enforce Plan Participant's Rights

1. If a Plan Participant's Claim for a plan Benefit is denied or ignored, in whole or in part, the Plan Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.
2. Under ERISA, there are steps the Plan Participant can take to enforce the above rights. A Plan Participant must exhaust all Claims and Appeal procedures available to him before filing any suit. For instance, if the Plan Participant requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the Plan Participant may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Plan Participant up to one hundred ten dollars (\$110.00) a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a Claim for Benefits, which is denied or ignored, in whole or in part, he may file suit in a state or federal court. In addition, if he disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such Plan Participant may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Plan Participant is discriminated against for asserting his rights, he may seek assistance from the United States Department of Labor, or he may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person he has sued to pay these costs and fees. If the Plan Participant loses, the court may order him to pay these costs and fees, for example, if it determines that his claim is frivolous.

E. Assistance with Plan Participant Questions

If a Plan Participant has any questions about his plan, he should contact the Plan Administrator. If a Plan Participant has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Plan Participant may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Article 23. CARE WHILE TRAVELING, MAKING PLAN CHANGES AND FILING CLAIMS

Blue Cross and Blue Shield of Louisiana is continuing to update its online access for Plan Participants. Plan Participants may now be able to perform many of the functions described below, without contacting Our customer service unit. We invite Plan Participants to log on to www.bcbsla.com for access to these services.

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of Our local service offices*, or from the home office of Blue Cross and Blue Shield of Louisiana. The Employee Enrollment / Change Form has the health questionnaire on the reverse side. If the Plan Participant needs to submit documentation to Us, the Plan Participant may forward it to Our home office at Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA 70898-9029, or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809.

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

A. How to Obtain Care While Traveling

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

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

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

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

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

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

C. How to File Claims for Benefits

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

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

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

1. an appropriate Claim form is used
2. the contract number (ID #) shown on the form is identical to the number on the ID card
3. the patient's date of birth is listed
4. the patient's relationship to the Plan Participant is correctly stated
5. all charges are itemized, whether on the Claim form or on the attached statement
6. the date of service (Admission to a Hospital or other Provider) or date of treatment is correct
7. the Provider includes a diagnosis and procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)
8. the Claim is completed and signed by the Plan Participant and the Provider

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

D. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

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

2. Outpatient Department Claims

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

3. Emergency Room Claims

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

4. Prescription Drug Claims

Most Plan Participants with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Plan Participants who present the ID card to a Participating Pharmacist. However, if the Plan Participant must file a Claim to access the Prescription Drug Benefit, the Plan

Participant must use the Prescription Drug Claim Form. Plan Participants may obtain the Prescription Drug Claim form by accessing the pharmacy section of Our website, www.bcbsla.com/pharmacy. The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Blue Cross and Blue Shield of Louisiana's Pharmacy Benefit Manager, whose telephone number can be found on the ID card.

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

5. Nursing Services Claims

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

6. Durable Medical Equipment (DME) Claims

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

7. Mental Health and/or Substance Use Disorders Claims

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

8. Other Medical Claims

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

NOTE: Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills.

Itemized bills submitted with Claim forms must include the following:

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

E. Claims Questions

Plan Participants can view information about the processing or payment of a Claim at www.bcbsla.com. Plan Participants can also write Us at the below address or call Our customer service department at the telephone number

shown on the ID card or visit any of Our local service offices*. If the Plan Participant calls for information about a Claim, We can help the Plan Participant better if they have the information at hand, particularly the contract number, patient's name and date of service.

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

Remember, the Plan Participant should ALWAYS refer to their contract number in all correspondence and recheck it against the contract number on the ID card to be sure it is correct.

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

Article 24. RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator

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

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

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

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

B. Duties of the Plan Administrator

1. to administer the Plan in accordance with its terms;
2. to interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
3. to decide disputes that may arise relative to a Plan Participant's rights;
4. to prescribe procedures for filing a Claim for Benefits and to review Claim denials;
5. to keep and maintain the Plan documents and all other records pertaining to the Plan;
6. to appoint a Claims Administrator to pay Claims;

7. to perform all necessary reporting as required by ERISA;
8. to establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609; and
9. to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

C. Plan Administrator Compensation

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

D. Fiduciary

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

1. Fiduciary Duties

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

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

2. The Named Fiduciary

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

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

E. The Claims Administrator is not a Fiduciary

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

LLHIGA NOTICE

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

- A. Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association, or LLHIGA. The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage. Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer. The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA

P.O. Drawer 44126
Baton Rouge, Louisiana 70804

Department of Insurance

P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

- B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S.22:2081 et seq. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.
- C. Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state; unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.
- D. Exclusion from Coverage
1. A person who holds a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:
 - a. he is eligible for protection under the laws of another state;
 - b. the insurer was not authorized to do business in this state;
 - c. his policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined by law, or any entity similar to any of these.

2. LLHIGA also does not provide coverage for:

- a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- b. any policy of reinsurance (unless an assumption certificate was issued);
- c. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
- d. dividends, premium refunds, or similar fees or allowances described under the law;
- e. credits given in connection with the administration of a policy by a group contract holder;
- f. employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
- g. unallocated annuity contracts (which give rights to group contract holders, not individuals), except if qualified by law
- h. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
- i. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A coverage", "Medicare Part B coverage", "Medicare Part C coverage", or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
- j. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

E. Limits on Amounts of Coverage

1. The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.
2. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:
 - a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
 - b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance.
 - c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$500,000 in health insurance benefits, and LLHIGA will pay a maximum of \$250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.
3. In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than \$500,000 in the aggregate with respect to any one individual.



Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238 or 1-800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨打 1-800-711-5519 (TTY 711)。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك. إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານພຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫຼຸບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس 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)

