NGF SMALL GROUP



BLUE POS

SMALL GROUP HMO BENEFIT PLAN

HMO Louisiana

HMO Louisiana Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross Blue Shield Association.

19636EX-025 R01/27

HMO Louisiana

Thank You for choosing Us!

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

My best to You,



Bryan R. Camerlinck
President and Chief Executive Officer

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Louisiana HMO Louisiana

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

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

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

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

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

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

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

Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana Inc., are independent licensees of the Blue Cross Blue Shield Association.

HMO LOUISIANA, INC. POINT OF SERVICE
GROUP HEALTH BENEFIT PLAN

NOTICES

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

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT WWW.LABLUE.COM OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

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

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

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

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

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

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

These covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as selected by You in consultation with Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to applicable cost share shown on the Schedule of Benefits.

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

REQUIREMENT TO SELECT A PRIMARY CARE PHYSICIAN (PCP)

This coverage requires You to designate a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Network and who is available to accept You or Your family members. Until You make this designation, We designate one for You. For children, You may designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of the PCPs in the Network, visit **www.lablue.com** or call the customer service phone number on the ID card. Additional information about Your PCP selection can be found in the Understanding the Basics of Your Coverage Article of this plan.

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

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

This Benefit Plan covers Prescription Drugs and uses a closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Benefit Plan. Drugs that are not listed on the formulary, also called non-formulary drugs are not covered. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost You less than drugs on higher tiers.

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

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

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

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

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

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

HMO Louisiana, Inc. issues this Benefit Plan to the Group/Policyholder shown on the Schedule of Benefits. A copy of this Benefit Plan provided to the Members serves as the Member's certificate of coverage. As of the Group's original Effective Date shown on the Schedule of Benefits, We agree to provide the Benefits specified herein for the Members of the Group. This Benefit Plan replaces any others previously issued to the Group/Policyholder, as of the amended Effective Date shown on the Schedule of Benefits. This Benefit Plan describes Member Benefits, as well as Member rights and responsibilities. We encourage You, the Member, 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 Benefit Plan. You may not have all of the information You need by reading just one section. Please be aware that Your Physician does not have a copy of Your Benefit Plan, and is not responsible for knowing or communicating Your Benefits to You.

Except for necessary technical terms, common words are used to describe the Benefits provided under this Benefit Plan. We, Us and Our mean HMO Louisiana, Inc. You, Your and Yourself mean the Member and/or enrolled Dependent. Capitalized words are defined terms in the Definitions Article of this Benefit Plan. A word used in the masculine gender applies also in the feminine gender, except where otherwise stated. The terms cost share and/or cost sharing mean the Deductible Amount, Coinsurance, and Copayments, when applicable to the Benefit Plan.

A. This Coverage and the Patient Protection and Affordable Care Act

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

B. Facts About This HMO Point of Service Benefit Plan

This is a point of service Benefit Plan. You have an extensive Network of Providers available to You – the HMOLA Network. You can get care from Providers in the Network, or from Providers who are not in the Network. If You get care from Providers in the Network, You will pay the least for your care and get the most value from this Benefit Plan. You usually pay a Copayment to a Network Provider at the time of service.

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

If a Copayment is shown on the Schedule of Benefits, You must pay the Copayment to the Network Provider each time You receive the Covered Services listed. Some services may require You to pay multiple Copayments. Benefits may be subject to Your payment of a Deductible Amount. After payment of Deductible Amounts, Benefits are subject to Coinsurances (for example, 80/20, 60/40). Your choice of a Provider determines what Deductible Amount and Coinsurance applies to the service provided. If applicable, We will pay the highest Coinsurance for Medically Necessary services when You go to a Provider in the HMOLA Network. If applicable, We will pay the lower Coinsurance when You receive Medically Necessary services from a Provider who is not in the HMOLA Network. Applicable cost share are shown on the Schedule of Benefits.

C. Our HMOLA Provider Network

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

We use the term Network Benefits to mean the highest level of Benefits payable under this Benefit Plan when the Member uses Providers in the HMOLA Network. We use the term Non-Network Benefits to mean a lower level of Benefits, if a Member chooses to go outside the HMOLA Network for care. To receive Network Benefits, the Member should always verify that a Provider is a current HMOLA Network Provider. Visit Our website at

www.lablue.com, or call customer service at the number listed on the ID card to verify that a Provider is a current HMOLA Network Provider, or to request a paper Provider directory. Our HMOLA Network may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas.

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

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

We pay a lower level of Benefits when a Member uses a Provider outside the HMOLA Network. Benefits may also be based on a lower Allowable Charge. The Member will usually pay Deductible Amount and Coinsurance instead of a Copayment. Receiving care from a Non-Network Provider will result in higher costs to the Member. We recommend that You ask the Non-Network Physician or healthcare professional about their billed charges before You receive care.

D. Using a Primary Care Physician (PCP)

This plan is sold with or without an office visit Copayment. The Schedule of Benefits will state whether a Copayment applies. If a Copayment for office visits is shown on the Schedule of Benefits, this direct access plan allows You to receive care from a PCP or from a Specialist. No PCP referral is required prior to accessing care directly from a Specialist in the HMOLA Network.

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

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

E. United Concordia Dental Advantage Plus Network

Pediatric Dental Care Benefits are covered under this Benefit Plan for Members under age nineteen (19). United Concordia Companies, Inc. d/b/a United Concordia Dental (UCD) is HMO Louisiana, Inc.'s network and claims administrator for dental Benefits and is in charge of managing the Advantage Plus Network, handling and paying Claims, and providing customer service to the Members eligible to receive these Benefits.

United Concordia Dental Advantage Plus Network consists of a select group of Providers who have contracted with United Concordia Dental to render services to Members for reduced amounts. **All other Providers are considered Non-Participating.** Non-Participating Providers may bill You more for their services than Participating Providers.

In order to receive full pediatric dental Benefits, the Member should verify that a Provider is an Advantage Plus Network Participating Provider before any service is rendered. To locate a Participating Provider and verify their continued participation in the Advantage Plus Network, or to ask any questions related to Benefits or Claims, please visit the website at **www.lablue.com** or contact a customer service representative at (866) 445-5338.

We, Us and Our means United Concordia Dental when it acts on behalf of HMO Louisiana, Inc. in performing its services under the dental coverage provided in the Articles for Oral Surgery Benefits and Pediatric Dental Care Benefits.

Reimbursements for services rendered by a Non-Participating Provider will be based on Our Allowable Charge and will be paid in the same amounts, under the same limits, rules and policies that We would have applied to Claims for services rendered by a Participating Provider. Care received from a Non-Participating Provider will mean a higher cost to You. We recommend that You ask the Non-Participating Provider about their billed charges before You receive care.

F. Davis Vision Network

Davis Vision, Inc. (hereinafter, Davis Vision) is the Company's network and claims administrator for the vision Benefits provided, and is in charge of managing the Davis Vision Network, handling and paying Claims, and providing customer service to the Members under age nineteen (19) eligible to receive these Benefits.

The Davis Vision Network consists of a select group of Providers who have contracted with Davis Vision to render services and supplies to Members for minimal out-of-pocket amounts. **All other Providers are considered Non-Participating.**

In order to receive the full Benefits under this section, the Member should verify that a Provider is a Davis Vision Network Participating Provider before any service is rendered. To locate a Participating Provider and verify their continued participation in the Davis Vision Network, or to ask any questions related to Benefits or Claims, please visit the website at **www.davisvision.com** or contact a customer service representative at 1-800-247-9368.

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

Members have access to Emergency and non-Emergency care outside Louisiana and around the world. The Member's ID card offers convenient access to Covered Services through Providers throughout the United States and in more than two hundred (200) countries worldwide.

In the United States:

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

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

Outside the United States:

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

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

How to Get Care Outside the Service Area:

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

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

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

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

5. The Member must obtain any required Authorizations from HMO Louisiana, Inc.

H. Authorizations

Some services and supplies require Authorization from Us before services are obtained. The Schedule of Benefits lists the services, supplies and Prescription Drugs that require Authorization. For more information on those items and services that require Authorization visit the website, **www.lablue.com/priorauth**. See the Care Management Article of this Benefit Plan for additional information regarding Authorization requirements.

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

HMOLA Network Providers are required to obtain necessary Authorizations on behalf of the Member. When an HMOLA Network Provider fails to obtain a required Authorization, We penalize the HMOLA Network Provider, not the Member, as described on the Schedule of Benefits. The Member continues to be responsible only for the applicable HMOLA Network cost share shown on the Schedule of Benefits.

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

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

I. How We Determine What We Pay for the Member's Covered Services

When the Member uses Network Providers

Network Providers have signed a contract with Us to participate in the HMOLA 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. Members 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 Member uses Participating Providers

Participating Providers have not a signed contract with the HMOLA Network, but have signed contracts with Blue Cross and Blue Shield of Louisiana or another independent Blue Cross and Blue Shield plan 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.

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

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

within a seventy-five (75) mile radius of the Member's home. To file an Appeal, the Member must follow the Appeal procedures in this Benefit Plan.

An Appeal for Network Benefits will not be approved for a Participating Provider outside the seventy-five (75) mile radius if there is a Network Provider who can perform the same or other appropriate Medically Necessary services to diagnose or treat the Member within the distance the Member traveled to receive care from the Participating Provider, no matter how many miles that may be.

When the Member uses Non-Participating Providers

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

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

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

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

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

An Appeal for Network Benefits will not be approved for a Non-Participating Provider outside the seventy-five (75) mile radius if there is a Network Provider who can perform the same or other appropriate Medically Necessary services to diagnose or treat the Member within the distance the Member traveled to receive care from the Non-Participating Provider, no matter how many miles that may be.

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

J. Sample Illustration of Member 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 Member's actual Copayments, Deductible Amounts and Coinsurances. Please refer to the Schedule of Benefits to determine Your Benefits.

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

If the Member receives Covered Services from:	Network Hospital	Participating Hospital	Non-Participating Hospital
Hospital Bill:	$12,000	$12,000	$12,000
Allowable Charge:	$2,500	$3,000	$2,500
We pay:	$2,500 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**
The Member pays:	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 Member billed up to the Hospital's billed charge?	NO	NO	YES $9,500
Total the Member pays:	**$500**	**$1,200**	**$10,500**

K. When A Member Purchases Covered Prescription Drugs

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

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

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

L. Mental Health and Substance Use Disorder Benefits

For help with Mental Health and Substance Use Disorder Benefits, the Member should refer to the Schedule of Benefits, ID card or call Our customer service department.

M. Member Incentives and Value-Added Services

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

N. Health Management and Wellness Tools and Resources

We offer Members a wide range of health management and wellness tools and resources. Members can use these tools to manage their personal accounts, see Claims history, create health records and access a host of online wellness interactive tools. Members also have access to a comprehensive wellness program that includes a personal health assessment and customized health report to assess health risks based on their history and habits. Exclusive

discounts are also available to Members on some health services such as fitness club memberships, diet and weight control programs, vision and hearing care and more.

O. Customer Service E-Mail Address

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

P. Identity Protection Services

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

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

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

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

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

A Member ceases to be eligible for these services if health coverage is terminated during the Plan Year. If health coverage is terminated during the Plan Year, Identity Protection Services will be provided to the Member through the end of the Plan Year.

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

ARTICLE II. DEFINITIONS

The inclusion of any definition in this Article does not denote that any particular benefit, condition, diagnosis, procedure, service, or treatment is necessarily covered under this Benefit Plan. Please review the Benefit Plan in its entirety to determine Your coverage.

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, biting, clenching, or grinding of teeth are not accidental injuries to teeth. If Benefits are available to treat a particular injury, Your Benefit Plan will cover an injury that results from an act of domestic violence.

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

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

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

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

C. any prospective or retrospective review determination;

D. a Rescission; or

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

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

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

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

Allowable Charge –

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

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

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

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

    3. the Provider's billed charge.

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

Ambulance Service – Medically Necessary transportation by a specially designed Emergency vehicle for transporting the sick and injured. The vehicle must be equipped as an Emergency transport vehicle and staffed by trained ambulance personnel as required by appropriate state and local laws governing an Emergency transportation vehicle.

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

A. anesthesia services as needed for medical operations and procedures performed;

B. provisions for physical and emotional well-being of patients;

C. provision for Emergency Medical Services;

D. organized administrative structure; and

E. administrative, statistical and medical records.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Company – HMO Louisiana, Inc. (HMOLA)

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

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

Concurrent Care – Hospital Inpatient medical and surgical care by a Physician, other than the attending Physician:

A. for a condition not related to the primary diagnosis; or

B. because the medical complexity of the patient's condition requires additional medical care.

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

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

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

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

Copayment (Copay) – The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member 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 rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to:

A. Providing personal care; homemaking; moving the patient;

B. Acting as companion or sitter;

C. Supervising medication that can usually be self-administered;

D. Treating or providing services that any person may be able to perform with minimal instruction; or

E. Providing long-term treatment for a condition in a patient who is not expected to improve or recover.

We determine which services are Custodial Care.

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

Deductible Amounts –

A. Individual Deductible Amount –

   1. The dollar amount, as shown on the Schedule of Benefits, of Allowable Charges for Covered Services that a Member must pay within a Benefit Period before the Benefit Plan starts paying Benefits. A separate Deductible Amount may apply to certain Covered Services if shown as applicable on the Schedule of Benefits.

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

B. Family Deductible Amount – The dollar amount, if shown on the Schedule of Benefits, for each category of Benefits to which a Deductible 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 Member 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, which is defined as that practice in which a person:

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

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

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

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

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

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

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

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

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

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

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

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

Emergency – See Emergency Medical Condition.

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

Emergency Medical Condition (Emergency) – A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

A. placing the health of the person, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;

B. serious impairment to bodily function; or

C. serious dysfunction of any bodily organ or part.

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

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

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

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

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

   1. Covered Services under the Benefit Plan;

   2. Furnished after the Member is stabilized; and

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

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

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

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

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

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

Exchange – The health insurance marketplace that is operated by the federal government for the State of Louisiana under Section 1311 of the Patient Protection and Affordable Care Act.

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

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

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

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

Expedited External Appeal – A request for immediate review, by an Independent Review Organization, 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 Member or jeopardize the Member's ability to regain maximum function.

B. A decision to not Authorize an Admission, availability of care, continued Hospital stay or healthcare service for Members 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 Member's health, including severe pain, potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the health of the Member.

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

Full Time Equivalent (FTE) – An Employee who:

A. is employed on an average thirty (30) or more hours per week; or

B. is working less than thirty (30) hours per week on average, but is in the stability period defined under Internal Revenue Code §54.4980H-2(c) and regulations issued thereunder, and is documented and verified by the Employer to be in the stability period.

A temporary employee does not meet the eligibility requirements under this Benefit Plan, unless such temporary employee is determined to be a Full Time Equivalent.

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

Generic Drug – A Prescription Drug that is equivalent to a Brand-Name Drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use; or that We identify as a Generic Drug.

Classification of a Prescription Drug as a Generic Drug is determined by Us and not by the manufacturer or pharmacy. We classify a Prescription Drug as a Generic Drug based on a nationally recognized pricing source; therefore, all products identified as a Generic by the manufacturer or a pharmacy may not be classified as a Generic by Us.

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

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

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

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

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

Home Visiting Services – Home visiting services are evidence-based deliveries of services to families of newborns, or families expecting newborns, provided by trained professionals in the home that begin anywhere from before the twenty-eighth week of pregnancy and up to six weeks after the birth of a child and continuing from up to two to five years after childbirth.

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

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

Imaging Services –

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

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

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

Independent Review Organization (IRO) – An entity, not affiliated with Us, 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 Members 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 Member by a Non-Network Provider that must be executed by a Member in order for a Non-Network Provider to obtain the Member's consent to receive medical treatment and services from the Non-Network Provider without the protections provided by the No Surprises Act.

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

Intensive Outpatient Programs – An Outpatient treatment program that provides a planned and structured, intensive level of care of at least two (2) hours per day and three (3) days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a Mental Disorder and/or a substance use disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services and adjunctive services, such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured crisis intervention programs, psychiatric or psychosocial rehabilitation, and some day treatment. Although treatment for substance use disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes time spent in these self-help programs, which are offered by community volunteers without charge.

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

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

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

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

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

    3. reference to federal regulations.

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

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

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

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

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

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

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

Member – A Subscriber or an enrolled Dependent.

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

A. psychoses,

B. neurotic disorders,

C. personality disorders,

D. affective disorders,

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

E. schizophrenia or schizoaffective disorder;

F. bipolar disorder;

G. panic disorder;

H. obsessive-compulsive disorder;

I. major depressive disorder;

J. anorexia/bulimia;

K. intermittent explosive disorder;

L. post-traumatic stress disorder;

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

N. Rett's Disorder;

O. Tourette's Disorder, and

P. unless otherwise determined by Us, 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, as determined by the Company.

The definition of Mental Disorder (Mental Health) shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Network Benefits – Benefits for care received from an HMOLA Network Provider. Network Benefits may also be referred to as In-Network.

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

Network Provider – A Provider that has signed an agreement with Us to participate as a member of the HMOLA Provider Network. This Provider may be referred to as an HMOLA Network Provider or an In-Network Provider.

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

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

Non-Network Benefits – Benefits for care received from Non-Network Providers. Non-Network Benefits may also be referred to as Out-of-Network.

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

Non-Preferred Brand/Generic Drug – A Prescription Drug that is a Brand-Name Drug or a Generic Drug that may have a therapeutic alternative known as 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 Period – A period of time each year designated by the Group or by federal government, during which a Subscriber and any eligible Dependents may enroll for coverage under this Benefit Plan.

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

Out-of-Pocket Amount – The maximum amount, as shown on the Schedule of Benefits, of unreimbursable expenses which must be paid by a Member for Covered Services in one (1) Benefit Period.

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

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

Partial Hospitalization Programs – Programs that provide structured and medically supervised day, evening and/or night treatment for at least four (4) hours per day and three (3) days per week, although some patients may need to attend less often. The services are of essentially the same nature and intensity (including medical and nursing) as would be provided in a Hospital, except that the patient is in the program less than twenty-four (24) hours per day. Patients are not considered residents at the program. The range of services offered is designed to address a Mental

Health and/or a substance use disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

Participating Pharmacy – See Network Pharmacy.

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

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

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

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

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

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

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

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

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

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

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

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

Primary Care Physician (PCP) – A Physician who is a family practitioner, general practitioner, internist, geriatrician, 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 (R.N.) or Licensed Practical Nurse (L.P.N.) who is unrelated to the patient by blood, marriage or adoption. These services must be ordered by the attending Physician and require the technical skills of an R.N. or L.P.N.

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

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

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

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

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

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

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

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

Qualified Health Plan – A plan that is determined as qualified to be sold through the Exchange under Section 1301 of the Patient Protection and Affordable Care Act.

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

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

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

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

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

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

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

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

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

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

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

Service Area – Those parishes in Louisiana shown in the HMOLA Provider Directory, which lists all HMOLA Network Physicians, Hospitals and Allied Providers in the Service Area.

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

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

B. full-time supervision by at least one Physician or registered nurse;

C. twenty-four (24) hour nursing service by registered nurses or licensed practical nurses; and

D. utilization review plans for all patients.

Sound Natural Tooth – A healthy natural tooth that is functioning in the mouth; is organically formed by natural development of the body (not artificial or manufactured); is not predisposed to injury due to extensive restoration, disease, or decay; and has at least fifty percent (50%) bony support. Examples of teeth that are not Sound Natural Teeth are teeth that are included in bridges, have received root canal treatment, have extensive restoration or restorative material, or have caps and/or crowns.

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

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

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

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

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

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

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

C. unique patient compliance and safety monitoring requirements;

D. unique requirements for handling, shipping and storage;

E. restricted access or limited distribution.

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

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

Spouse – The Subscriber's legal Spouse.

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

Surgery –

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

B. The correction of fractures and dislocations.

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

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

E. Other procedures as defined and approved by Us.

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

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

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

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

Temporomandibular Joint (TMJ) Disorders – Disorders resulting in pain or dysfunction of the temporomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes. Temporomandibular Joint (TMJ) Disorders do not include pain or dysfunction of the temporomandibular joint caused by acute dental conditions (e.g., caries or periodontal disease), acute and chronic sinus disease, carotidynia, cervical spine pathology, disorders of the salivary glands, otologic (ear) disorders, neuralgias of the head and neck, and headache syndromes (migraine, cluster and/or tension). Note that the exclusion of the foregoing listed conditions from the definition of Temporomandibular Joint (TMJ) Disorders does not necessarily mean those listed conditions are Covered Services under this Benefit Plan.

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

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

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

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

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

Waiting Period – See Eligibility Waiting Period.

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

ARTICLE III. SCHEDULE OF ELIGIBILITY

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

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

A. Eligibility

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

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

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

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

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

   a. Spouse

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

      (1) born of the Subscriber; or

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

      (3) legally adopted by the Subscriber; or

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

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

      (6) a stepchild of the Subscriber; or

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

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

B. Application for Coverage

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

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

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

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

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

5. If the Group covers retirees, retirees must be enrolled in the 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 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 Group as shown on the Application for Group Coverage. The Group has the right to change the classes of coverage selected when needed.

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

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

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

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

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

D. Effective Date

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

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

2. If a person becomes an Eligible Person after this Group's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s) on or before the eligibility date and the enrollment form is received

by the Company within thirty (30) days of the eligibility date, the Effective Date of coverage will be the eligibility date.

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

4. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and family coverage or Subscriber and child(ren) coverage), and the enrollment form is received by the Company within thirty (30) days of the date of birth, the Effective Date of coverage will be the date of birth.

E. Court Ordered Determination

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

F. Special Enrollment

Special Enrollment Periods exist outside of the Open Enrollment Period when the Eligible Person experiences a specific special enrollment event as described under this section. During these periods, application may be made to the Company to enroll or drop coverage or to enroll or disenroll Dependents. Individuals who lose other coverage because they did not pay their premiums or required contributions timely, or lose other coverage for cause (such as filing fraudulent Claims or an intentional misrepresentation of a material fact in connection with the plan), are not Special Enrollees and have no special enrollment rights.

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

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

   b. If the Eligible Person was offered coverage under this Benefit Plan on a previous Open Enrollment Period, the Eligible Person must have declined enrollment in writing in a form established by the Company for that purpose.

2. Examples of special enrollment events are:

   a. Enrollment or non-enrollment in this Benefit Plan was due to an error, misrepresentation or inaction of an officer, employee or agent of the Company or the United States Department of Health and Human Services, or their instrumentalities.

   b. The Company's substantial violation of a material provision of this Benefit Plan.

   c. Gaining access to new Qualified Health Plans because of a permanent move.

   d. Being an Indian, as defined in Section 4 of the Indian Health Care Improvement Act.

   e. Meeting other exceptional circumstances as determined by the Company.

   f. The Subscriber gaining a Dependent or gaining dependent status under another health plan through marriage, birth, adoption, placement for adoption or mandate granting legal or provisional custody. Premiums may be adjusted for the additional coverage if adding the new Dependent changes the class of coverage under the Benefit Plan. When the Subscriber gains dependent status under another plan, the Subscriber may disenroll from this Benefit Plan outside of the Open Enrollment Period. When the Subscriber gains a Dependent and because of that wishes to enroll himself, or enroll a Dependent in this Benefit Plan, the following rules apply:

(1) If not already participating, an Eligible Employee may enroll with the Dependent if the Eligible Employee has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period. In the case of the birth, adoption, or placement for adoption of a child, the Spouse of the Employee may be enrolled as a Dependent if the Spouse is otherwise eligible for coverage.

(2) If the Group offers multiple health plan options, another option may be chosen by the Eligible Employee for himself and Dependents when special enrollee status applies.

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

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

(5) In the case of a birth, adoption, or placement for adoption, a current Employee may enroll, enroll the Spouse and/or the newborn/adopted child and other eligible Dependent children, but the enrollment must be requested no later than thirty (30) days after the birth, adoption, or placement for adoption. If the enrollment form is received by the HMO Louisiana, Inc. office no later than thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth for a natural Newly Born Infant, and upon the date of adoption, or placement for adoption for an adopted Newly Born Infant. A Subscriber may enroll an unborn natural child prior to birth; however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth. If the request for enrollment is not made and received by Us within thirty (30) days of birth, adoption or placement for adoption, the request for special enrollment will be denied and any automatic coverage period will end.

(6) In the case of marriage, a current Eligible Employee may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested within thirty (30) days of the marriage. The special enrollment will be denied if the enrollment is not requested within thirty (30) days of the marriage.

(7) Loss of minimum essential coverage during the Plan Year as that term is defined under Internal Revenue Code Section 5000A, such as:

(a) Medicare.

(b) Medicaid or the Children's Health Insurance Program (CHIP), if either:

(i) The Eligible Employee or Dependent is covered under Medicaid or Children's Health Insurance Program (CHIP), and lose that coverage because of loss of eligibility; or

(ii) the Eligible Employee or Dependent becomes eligible for premium assistance under the CHIP program.

To qualify, an Eligible 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 Eligible Employee or Dependent is determined to be eligible for such premium assistance. Request for special enrollment under this section must be received by the HMO Louisiana, Inc. office within the sixty (60) day period following loss of coverage or the date the Eligible Employee or Dependent is determined to be eligible for premium assistance. When special enrollment under this section is made timely and received by the Company timely, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP or the date the Eligible Employee or Dependent is eligible for premium assistance.

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

(c) Health coverage provided by the United States Armed Forces under Chapter 55 of Title 10 of the United States Code, including Tricare.

(d) Health coverage program provided by the United States Secretary of Veterans Affairs in coordination with the United States Secretary of Health and Human Services under Chapters 17 and 18 of Title 38 of the United States Code.

(e) The health plan for Peace Corps volunteers under Section 2504(e) of Title 22 of the United States Code.

(f) The Non-appropriated Fund Health Benefits Program of the United States Department of Defense, established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995.

(g) Health plans purchased in the individual health insurance market within a State of the United States.

(h) Coverage under the health benefits risk pool of a State of the United States.

(i) Any other plan recognized as minimum essential coverage by the United States Secretary of Health and Human Services in coordination with the United States Secretary of the Treasury for purposes of Internal Revenue Code Section 5000A.

(j) Another Employer-sponsored plan.

In the case of another Employer-sponsored plan, such loss of minimum essential coverage must be due to loss of eligibility for coverage as a result of:

(i) Termination of employment (except for gross misconduct),

(ii) Reduction of work hours,

(iii) Death,

(iv) Divorce,

(v) Loss of dependent status,

(vi) Termination of Employer contributions towards a person's coverage,

(vii) The plan stops offering Benefits to a certain class of similarly situated individuals,

(viii) Changing residence to an area not served by the plan, or

(ix) Exhaustion of COBRA continuation coverage because of:

1. the full COBRA continuation period was exhausted;

2. the Employer or other responsible entity failed to remit required premiums on a timely basis;

3. the individual whose coverage is through a Health Maintenance Organization (HMO), no longer lives, resides or works in the Service Area, whether or not the choice of the individual in the Service Area, and there is no other COBRA coverage available;

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

3. A Special Enrollee due to loss of eligibility for coverage under another Employer-sponsored plan 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 coverage). If such enrollment for coverage is received by the HMO Louisiana, Inc. office within thirty (30) days after loss of other coverage, coverage will become effective on the date other coverage is lost. If the enrollment is not received within thirty (30) days of the loss of other coverage, coverage under this Benefit Plan will be denied and must be requested during the next Open Enrollment Period.

ARTICLE IV. BENEFITS

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

A. Benefit Categories

1. Network Benefits (In-Network) – Benefits for medical care received from a HMOLA Network Provider. When a Member receives care from a Network Provider, the Member will receive the highest level of Benefits on this plan.

2. Non-Network Benefits (Out-of-Network) – Benefits for medical care received from a Provider who is not contracted with Us as a HMOLA Network Provider. Participating Providers and Non-Participating Providers are not contracted with the HMOLA Network. When a Member receives care from a Non-Network Provider, the Member will receive a lower level of Benefits on this plan.

B. Deductible Amounts

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

    a. Individual Deductible Amount: The dollar amount, as shown on the Schedule of Benefits, of charges for Covered Services that a Member 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: For Members in a class of coverage with more than one Member, this aggregate amount shown on the Schedule of Benefits is the maximum Deductible Amount that the family must pay before this Benefit Plan starts paying Benefits. Once the family has met its Family Deductible Amount, this Benefit Plan starts paying Benefits for all members of the family, even if each family member has not met the Individual Deductible Amount. No family member may contribute more than the Individual Deductible Amount to satisfy the aggregate amount required of a family. Only Individual Deductible Amounts accrue to the Family Deductible Amount.

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

2. Each of the Deductible Amounts listed on the Schedule of Benefits may have separate Network and Non-Network amounts. Amounts that apply to a Network Deductible Amount do not apply to a Non-Network Deductible Amount. Amounts that apply to a Non-Network Deductible Amounts do not apply to a Network Deductible Amount.

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

4. If the Company pays a healthcare Provider amounts that are Your responsibility, such as applicable cost share shown on the Schedule of Benefits, the Company may collect such amounts directly from You. You agree that the Company has the right to collect such amounts from You.

C. Coinsurance

If a Coinsurance is shown on the Schedule of Benefits for a Covered Service, the Member must first pay any applicable Deductible Amount before the Coinsurance. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, We will provide Benefits in the Coinsurance shown on the Schedule of Benefits toward Allowable Charges for Covered Services. Our actual payment to a Provider or payment to the Member satisfies Our obligation to provide Benefits under this Benefit Plan.

D. Copayment Services

The Member may pay one or more Copayments each time applicable Covered Services are rendered, until the Member meets the Out-of-Pocket Amount. The amount of the Copayment depends on the service and on the designation and type of Network Provider rendering the service. Office visit Copayments, if applicable, will be shown on the Schedule of Benefits.

1. Examples of Covered Services subject to Copayments:

    a. Office visits and consultations;

    b. Surgical procedures performed in the Physician's office; and

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

    b. Allergy testing;

    c. Anesthesia;

    d. Chemotherapy;

    e. Radiation therapy;

    f. Low-Tech Imaging;

    g. Lab tests;

    h. Dialysis;

    i. Infusion therapy; and

    j. Medical and Surgical supplies.

E. Out-of-Pocket Amount

1. After the Member has met the applicable Out-of-Pocket Amount 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. Deductible Amounts;

    b. Coinsurances; and

c. Copayments.

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

   a. any charges in excess of the Allowable Charge;

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

   c. charges for non-Covered Services.

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

F. Accumulator Transfers

Members' needs sometimes require that they transfer from one policy to another. Types of transfers include, but are not limited to moving from one Employer's plan to another, from a change in assignment to a different plan variation of the same Qualified Health Plan during a Benefit Period, from a group policy to an individual policy, an individual policy to a group policy, or a Blue Cross and Blue Shield of Louisiana policy to an HMO Louisiana, Inc. policy. The type of transfer being made determines whether the Member's accumulators are carried from the old policy to the new policy. Accumulators include, but are not limited to, Deductible Amounts, Out-of-Pocket Amounts, and Benefit Period maximums.

ARTICLE V. HOSPITAL BENEFITS

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

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

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.

2. In a Special Care Unit for a critically ill Member requiring an intensive level of care.

3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us.

4. In a Residential Treatment Center for Members with Mental Health and substance use disorder Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

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

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

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

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

5. Medical and Surgical supplies, casts and splints.

6. Diagnostic Services rendered by a Hospital employee.

7. Physical Therapy provided by a Hospital employee.

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

C. Emergency Medical Services

The Member must pay applicable cost share shown on the Schedule of Benefits for each visit the Member makes to a Hospital or facility for treatment of an Emergency Medical Condition.

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 VI. MEDICAL AND SURGICAL BENEFITS

Benefits for the following medical and surgical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. The Member must pay applicable cost share shown on the Schedule of Benefits.

A. Surgical Services

1. Surgery

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

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

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

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

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

   b. Secondary Service

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

   c. Incidental Service

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

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

d. Unbundled Services

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

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

e. Mutually Exclusive Services

(1) Mutually exclusive services are two (2) or more services that usually are not performed at the same operative session or encounter on the same patient, on the same date of service, and for which separate billings are made. Mutually exclusive services may also include different service code descriptions for the same type of services in which the Physician should be submitting only one (1) of the codes. One 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, an 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 are available for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. The Physician that provides a second or third opinion must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory to receive Benefits.

B. Inpatient Medical Services

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

1. Inpatient medical care visits;

2. Concurrent Care; and

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

C. Outpatient Medical and Surgical Services

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

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

3. Diagnostic Services.

4. Services of an Ambulatory Surgical Center.

5. Services of an Urgent Care Center.

D. Classification of Benefits as Medical Surgical (MS) Benefits Versus Mental Health/Substance Use Disorder (MH/SUD) Benefits

1. Benefits shall be categorized as either Medical/Surgical (MS Benefits) Benefits or Mental Health (MH) and Substance Use Disorder (SUD) Benefits (collectively termed MH/SUD Benefits) according to the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

2. Specific benefits offered and services provided may be mapped to either category of MS Benefits or MH/SUD Benefits depending on the diagnosis.

3. For purposes of the classification, the following definitions are applicable:

   a. Medical/Surgical (MS) Benefits – Benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the Benefit Plan, and in accordance with applicable federal and state law, but not including MH/SUD Benefits.

   b. Mental Health/Substance Use Disorder (MH/SUD) Benefits – Mental Health (MH) Benefits with respect to items or services for mental health conditions, as defined under the terms of the Benefit Plan and in accordance with applicable federal and state law. Substance Use Disorder (SUD) Benefits mean benefits with respect to items or services for substance use disorders, as defined under the terms of the Benefit Plan and in accordance with applicable federal and state law. MH/SUD Benefits include conditions and diseases listed in the most recent edition of the International Statistical Classification of Diseases and Related Health Problems (ICD) as psychotic disorders, mood disorders, stress-related disorders, personality and mental retardation; other nonpsychotic mental disorders listed in the ICD, to be determined by Us; or disorders listed in the ICD requiring treatment for misuse or dependence upon substances such as alcohol, narcotics, or hallucinogens.

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

Prescription Drugs are covered as shown in either Option 1 or Option 2 below. Refer to Your Schedule of Benefits to see which Prescription Drug Benefit applies to You.

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

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

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

D. Prescription Drug Formulary

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

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

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

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

Option 1 – Prescription Drug Benefits (Four Tier)

1. The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Member may be required to pay a different Copayment or

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

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

3. If a formulary exception request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary at Tier 3 if it is a non-Specialty Drug and at Tier 4 if it is a Specialty Drug.

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

   b. Tier 2 – Preferred Brand Drugs: Preferred Brand Drugs: Brand-Name Drugs

   c. Tier 3 – Non-Preferred Brand/Generic Drugs: 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: Specialty Drugs: High-cost Brand-Name Drugs or Generic Drugs that are identified as Specialty Drugs.

Option 2 – Prescription Drug Benefits (Two Tier)

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

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

   a. Tier 1: Generic Drugs

   b. Tier 2: Brand-Name Drugs

E. Drug Utilization Management Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

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

A. Well Woman Examinations and Counseling (Benefit Period Deductible does not apply)

1. Routine annual visits to Network Providers for obstetrical or gynecological care. Additional visits to a Provider for obstetrical or gynecological care may be subject to applicable cost share 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), contrast-enhanced mammograms, and breast ultrasounds are covered at no cost when obtained from a Network Provider. Mammograms obtained from a Non-Network Provider will be subject to Coinsurance as shown on the Schedule of Benefits.

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

5. Breastfeeding Interventions and Lactation Counseling are covered at no cost when obtained from a Network Provider.

B. Physical Examinations, Screenings and Testing

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

   High-Tech Imaging Services such as an MRI, MRA, CT Scan, PET Scan, and nuclear cardiology are not covered under this Preventive or Wellness Care Benefit. These High-Tech Imaging Services are covered under standard 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) prostate-specific antigen (PSA) test and digital rectal exam per Benefit Period, is covered for Members, ages 40 – 75, per applicable guidelines. A second visit shall be permitted for follow-up treatment within sixty (60) days after the visit if it is related to a condition that is diagnosed or treated during the visits.

4. Colorectal Cancer Screening – Fecal Immunochemical Test (FIT) for blood, Cologuard (FIT-fecal) DNA testing, Computed Tomographic (CT) colonography, flexible sigmoidoscopy, or routine colonoscopy provided in accordance with the most recently published recommendations when required to be covered by applicable federal and/or state law for the ages, family histories and frequencies referenced in such recommendations. Note, these services are only covered at one hundred percent (100%) of the Allowable Charge if received from a Network Provider when the Member is part of the recommended population for the screening, which are often limited to persons of average risk and not persons of increased risk. When a Member is not part

of the recommended population for a screening that is a Covered Service, the screening may be subject to applicable cost sharing. Routine colorectal cancer screening does not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational.

Selected generic Physician prescribed colonoscopy preparation and supplies for routine colonoscopies covered under the Preventive and Wellness Care Benefit will be covered at no cost to the Member when obtained from a Network Pharmacy. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Member only when the Physician prescribes brand-name colonoscopy preparation and supplies because the Member cannot tolerate selected generic colonoscopy preparation and supplies.

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

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

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

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

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

7. Patient Navigation Services for Breast Cancer and Cervical Cancer Screenings and Follow-Up – Patient navigation services will be provided at no cost to females eligible for routine breast cancer screening or cervical cancer screening and experiencing barriers to breast cancer screening or cervical cancer screening and follow-up only when those services are initiated by a clinician and obtained from Our care management department. Access these services by calling or emailing our care management department at 1-800-317-2299 or **CareManagementTeam@lablue.com**.

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

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

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

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

D. New Recommended Preventive or Wellness Care Services

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

ARTICLE IX. MENTAL HEALTH BENEFITS

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

B. **EFFECTIVE July 1, 2027 -** Coverage is also provided for mobile crisis services and/or behavioral health crisis services delivered by Providers authorized by Us to provide such services. These services are subject to Medical Necessity and the payment of any applicable cost share.

C. The first follow-up visit after discharge from an Inpatient facility for the treatment of a Mental Disorder is available at no cost to the Member when performed within seven (7) days of the discharge by a Network Provider approved by Us as a behavioral health Provider. Additional visits will be paid subject to standard Benefits.

ARTICLE X. SUBSTANCE USE DISORDER BENEFITS

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

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

ARTICLE XI. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, Providers in Your medical plan network, the Blue Cross and Blue Shield of Louisiana dental network, or the United Concordia Dental Advantage Plus Network are considered Network Providers. Access these Networks at **www.lablue.com** or call the customer service telephone number on the ID card for copies of the directories.

A. Covered Services or Procedures

1. Excision of tumors or cysts that do not originate from the teeth, gingiva (gums), and periodontal structures. Examples of covered tumors and cysts include salivary gland tumors or cysts and primary tumors of the mandible and maxilla, such as ameloblastoma and osteosarcoma. Cysts and tumors originating from the teeth, gingiva (gums), and periodontal structures, such as periapical cysts or abscesses and odontogenic cysts or keratocysts, are not covered. Excision of inflamed tissue related to periodontal disease is not covered.

2. Extraction of teeth when there is complete bony impaction of each tooth to be extracted.

3. Dental Care and Treatment required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of Sound Natural Teeth when received within seventy-two (72) hours of the onset of the Accidental Injury. Treatment must be completed within twelve (12) months of the onset of the Accidental Injury to a Sound Natural Tooth to be covered. The damage must be the result of an Accidental Injury to a Sound Natural Tooth struck from outside the mouth as a result of major trauma, which does not include injury caused by chewing, biting, clenching, or grinding of teeth. Coverage is limited to extraction of teeth needed to avoid infection of teeth damaged in the Accidental Injury; suturing; reimplanting and stabilization of dislodged Sound Natural Teeth; repositioning and stabilization of partly dislodged Sound Natural Teeth; and

appropriate plain film dental x-rays. If multiple treatment options exist, coverage will only be available for the least costly Medically Necessary treatment option.

The definitions of Accidental Injury and Sound Natural Tooth are those set forth in Article II of this Benefit Plan.

4. Excision of exostoses or tori of the jaws and hard palate when required for the fitting of a covered denture.

5. Anesthesia in any non-Hospital setting (for example, an Allied Health Facility, Ambulatory Surgical Center, or Office), including general anesthesia (e.g., monitored anesthesia care) and conscious sedation, when used for Medically Necessary Covered Services or procedures and when rendered or supervised by a Provider with a dental degree and the requisite training. Local anesthesia is always considered incidental to the covered dental service or procedure and is not eligible for separate reimbursement. Anesthesia for dental services is only reimbursable under this Benefit Plan when performed in conjunction with a Medically Necessary covered dental service or procedure that is covered under this Benefit Plan. If treatments, services or procedures are covered under the Member's separate or standalone dental plan, if applicable, then anesthesia is not covered under this Benefit Plan for such treatments, services or procedures.

6. Anesthesia when rendered in a Hospital or Outpatient Surgical facility and for associated Hospital or facility charges when the Member's mental or physical condition requires dental treatment, services, or procedures to be rendered in a Hospital or Outpatient Surgical facility.

7. Coverage is not available for conditions not listed below. Coverage based solely on a Member's level of fear or anxiety about a procedure is not covered unless it is documented in the Member's medical history that all other forms of behavior guidance noted below have been tried and failed. Because Temporomandibular Joint (TMJ) Disorders are not covered under this Benefit Plan, anesthesia for Temporomandibular Joint (TMJ) Disorders is also not covered under this Benefit Plan.

   Covered conditions include:

   a. Member is less than six (6) years old.

   b. Member has a severe disability including, but not limited to, epilepsy with a history of uncontrolled seizures; Mental Disorders or mental conditions such as autism or schizophrenia, Down syndrome, or severe cerebral palsy that have been documented in the Member's medical history by a Physician.

   c. Member has a serious underlying medical condition including, but not limited to, severe asthma; congestive heart failure; bleeding disorders that could lead to immediate or severe airway compromise; or conditions with known or suspected airway compromise that have been documented in the Member's medical history by a Physician.

   d. Requirement for immediate and comprehensive treatment that threatens the patency of the Member's airway.

   e. Requirement for significant restorative or surgical procedures that have not been able to be successfully provided to the Member using behavior guidance in the dental office, including communication techniques, parental presence or absence, nitrous oxide and oxygen inhalation, protective stabilization or oral sedation.

   f. Local anesthesia for the Member is contraindicated because of acute infection, anatomic variations that prevent adequate anesthesia or allergies to the medication.

   g. Other conditions in which a Physician has certified that general anesthesia in a Hospital setting is Medically Necessary for the Member or when other methods of behavior guidance in the dental office have been tried and documented to be unsuccessful for the Member, including communication techniques, parental presence or absence, nitrous oxide and oxygen inhalation, protective stabilization or oral sedation.

8. 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. Benefits for head and neck cancer patients are only available when a comprehensive dental evaluation for treatment of decay and abscesses was performed on the Member prior to the initiation of chemotherapy and/or radiation therapy. Benefits are only available for dental services that are not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies and those dental services are as likely to produce equivalent therapeutic or diagnostic results for diagnosing or treating patients' illness, injury or disease as the alternatives. To obtain more information on how to access these medical Benefits, please call Our customer service department at the phone number on the ID card, and ask to speak to a Case Manager.

9. Dental implants are only eligible for coverage when they are not primarily for personal comfort or convenience of patients or Providers and when the dental implants are not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies and are as likely to produce equivalent therapeutic results for restoring a patient to their baseline (i.e., pre-injury/pre-illness) status. Dental implants placed into previously radiated bone are excluded from coverage.

ARTICLE XII. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

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

Solid organ and bone marrow transplants will not be covered unless the Member obtains written Authorization from Us prior to services being rendered. The Member, or 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 Member and to the Provider(s).

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplants

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or by the HMOLA 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, Members should contact Our customer service department at the number listed on the ID card.

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

2. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedures.

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

   a. Solid Human Organ Transplants of the:

(1) liver;

(2) heart;

(3) lung;

(4) kidney;

(5) pancreas;

(6) small bowel; and

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

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

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

The following tissue transplants are covered:

(1) blood transfusions;

(2) autologous parathyroid transplants;

(3) corneal transplants;

(4) bone and cartilage grafting;

(5) skin grafting;

(6) autologous islet cell transplants; and

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

c. Bone Marrow Transplants

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

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

ARTICLE XIII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

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

An Authorization is required for a Hospital stay for a newborn whose stay in the Hospital continues after the discharge of the mother. An Authorization is also required for a newborn that is admitted separately from the mother because of neonatal Complications.

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

A. Pregnancy Care Benefits

1. Medical and Surgical Services

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

    b. Diagnostic Services.

    c. Delivery, including necessary prenatal and postnatal care.

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

2. Doula Services

    Maternity support services are available when provided by a registered Doula to pregnant and birthing women and their families before, during, and after childbirth. Benefits are limited to $1500 per pregnancy when services are rendered by a Network Doula and are subject to applicable cost share shown on the Schedule of Benefits. Services rendered by a Non-Network Doula are not covered.

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

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

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

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

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

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

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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

ARTICLE XIV. REHABILITATIVE AND HABILITATIVE CARE BENEFITS

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

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

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

A. Occupational Therapy

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

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

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

B. Physical Therapy

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

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

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

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

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

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

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

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

C. Speech/Language Pathology Therapy

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

2. The therapy must be used to improve or restore speech/language deficits, speech/language development disorders, cognitive communication, or swallowing function.

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

D. Chiropractic Services

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

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

ARTICLE XV. PEDIATRIC DENTAL CARE BENEFITS

The dental Benefits described in this section are available for Members under the age of nineteen (19) only.

Members who attain age nineteen (19) during a Plan Year will continue to have these Benefits until the end of that Plan Year. Members that age off the coverage under this section may be eligible to purchase other dental coverage through Blue Cross and Blue Shield of Louisiana. Please contact a customer service representative for details. The Schedule of Benefits controls the Benefits covered, the frequency with which they are covered, and the cost sharing applicable to each Benefit. The Benefits offered are limited.

In accordance with federal law, We will provide Benefits for all required pediatric dental services. Services will be subject to any duration and frequency limits and exclusions as identified in the federal benchmark plan.

A. Definitions that Apply Only to the Pediatric Dental Care Benefits

1. Allowable Charge – The lesser of the billed charge or the amount established by UCD as the greatest amount this Benefit Plan will allow for a specific service covered under the terms of this Benefit Plan.

2. Amalgam – A durable metal alloy comprised of silver, copper, tin and mercury, used in dental restorations.

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

4. Benefits – Coverage for dental services, treatments or procedures provided under this Benefit Plan. Benefits are based on the Allowable Charge for Covered Services and the Schedule of Benefits.

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

6. Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a percentage. Once the Member has met any applicable Deductible Amount, the Company's percentage will be applied to the Allowable Charge for Covered Services to determine the Benefits provided.

7. Cosmetic Surgery/Treatment – Any procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form. A procedure, treatment or service will not be considered Cosmetic Surgery or Treatment if that procedure, treatment or service restores bodily function or corrects deformity of a part of the body that has been altered as a result of Accidental Injury, disease or covered Surgery.

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

9. Crown – A tooth-shaped cap that is placed over a tooth to cover it and restore its shape and size, strength, and improve its appearance. When a Crown is cemented into place, it fully encases the entire visible portion of a tooth that lies at and above the gum line.

10. Deductible – The dollar amount, if shown on the Schedule of Benefits, of Allowable Charges for Covered Services that each Member must pay within a Benefit Period before payments are made under this Benefit Plan. If shown on the Schedule of Benefits, the Deductible may be waived for certain services.

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

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

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

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

12. Dental Implants – An artificial device that replaces the tooth root and may anchor an artificial tooth, bridge or denture.

13. Dental Necessity or Dentally Necessary – A dental service or procedure that is determined by UCD to either establish or maintain a patient's dental health based on professional diagnostic judgment and the prevailing standards of care in the professional community. The determination will be made by a Dentist in accordance with guidelines established by UCD.

14. Dentist – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include other duly licensed dental practitioners under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

15. Endodontic (Pulpal) Therapy – A dental procedure that is performed when the decay in a child's tooth reaches into the pulp (nerve) tissue. The infected part of the nerve tissue within the crown portion of the tooth is removed to prevent further inflammation and spread of disease (caries). During this treatment, the diseased pulp tissue is partially or completely removed from both the crown and the roots of the tooth. The canals are cleansed, disinfected, and filled with a special material.

16. Filling – A dental restorative material used to restore the function, integrity and form of missing tooth structure, which may result from caries or external trauma.

17. Fluoride Treatment – Fluoride is a chemical substance that helps prevent tooth decay by making the tooth more resistant to acid attacks from plaque bacteria and sugars in the mouth. It also reverses early decay. Fluoride treatment refers to the direct application of a substance containing this substance to the tooth enamel.

18. Gingivectomy – Surgical removal of gum tissue.

19. Gingivoplasty – A surgical procedure to reshape or repair the gums.

20. Inlay – A custom-made solid substance that is fitted into a cavity in a tooth between the cusps, which is cemented into place to restore its biting surface.

21. Occlusal Guard – A horseshoe shaped piece of plastic which is worn over the teeth to protect them against damage caused by clenching or grinding. It works by creating a physical barrier between the patient's upper and lower teeth so that the patient bites against the plastic rather than wearing down the teeth.

22. Onlay – A custom-made solid substance that works like an Inlay but covers one or more cusps or the entire biting surface of the tooth. It is usually used when the tooth is too damaged to support an Inlay, but not damaged enough to require a Crown.

23. Orthodontics – A dental specialty that treats misalignment of teeth.

24. Periodontal Scaling and Root Planing – The process of removing or eliminating etiologic agents (dental plaque, its products, and calculus) which cause inflammation, and help to maintain disease-free tissues that surround and support the teeth.

25. Prefabricated Stainless Steel Crown – A Crown made of stainless steel that is premanufactured in a variety of sizes and are intended to be fitted upon a child's primary tooth which is damaged, to simulate its original form, decrease the risk of future cavities, save the proper amount of space for the eruption of the permanent tooth, and restore the child's ability to bite and chew.

26. Prosthetic Dentures – Prosthetic devices constructed to replace missing teeth, and which are supported by surrounding soft and hard tissues of the oral cavity. Conventional dentures are removable; however, there are many different denture designs, some which rely on bonding or clasping onto teeth or Dental Implants.

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

    a. Participating Provider – A Provider that has a Provider Agreement with United Concordia Dental Advantage Plus Network to render Covered Services to a Member.

    b. Non-Participating Provider – A Provider that does not have a Provider Agreement with United Concordia Dental Advantage Plus Network to render Covered Services to a Member.

28. Provider Agreement – An agreement for payment contracted by UCD with Participating Providers. These agreements establish the actual payments which will be made to the Participating Provider.

29. Resin-Based Composite – Material composed of plastic with small glass or ceramic particles, which resemble the appearance of natural teeth.

30. Sealant – Plastic material usually applied to the chewing surfaces of the back teeth (premolars and molars) where decay occurs most often, so that they act as a barrier to prevent cavities.

31. Space Maintainer – Besides being useful for chewing, baby teeth also act as a guide for the eruption of the permanent teeth that replaces them. If a baby's tooth is lost too early, the permanent tooth that comes after it loses its guide, so it could drift or erupt into the wrong position in the mouth. Neighboring teeth also can move or tilt into the space, reducing the space available for the permanent tooth to come out. Space Maintainers are appliances used when a baby tooth is lost too early to help make room for the permanent tooth it was intended to guide.

32. Temporomandibular Joint (TMJ) Disorders – Disorders resulting in pain or dysfunction of the temporomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes. Temporomandibular Joint (TMJ) Disorders do not include pain or dysfunction of the temporomandibular joint caused by acute dental conditions (e.g., caries or periodontal disease), acute and chronic sinus disease, carotidynia, cervical spine pathology, disorders of the salivary glands, otologic (ear) disorders, neuralgias of the head and neck, and headache syndromes (migraine, cluster and/or tension).

33. UCD – United Concordia Companies, Inc. d/b/a United Concordia Dental, the network and claims administrator for the pediatric dental Benefits in this plan and oral Surgery provided by an Advantage Plus Network Provider.

B. Diagnostic and Preventive Services

After the Member's payment of applicable cost share shown on the Schedule of Benefits this Benefit Plan will cover:

1. Oral Exams

    a. One (1) periodic, limited problem-focused or comprehensive oral exam every six (6) months.

    b. One (1) detailed problem-focused oral evaluation every six (6) months.

2. Oral Cleanings (Prophylaxis)

    a. Limited to one (1) every six (6) months.

    b. One (1) additional cleaning during the Plan Year will be allowed for Members that are under the care of a medical professional during pregnancy.

3. Fluoride Treatment

    a. Limited to children under nineteen (19) years old; and

    b. Limited to two (2) topical applications every twelve (12) months.

4. Sealants

    a. Limited to children under nineteen (19) years old, and only for permanent first and secondary molars; and

    b. Limited to one (1) per tooth every thirty-six (36) months.

5. Consultations

    Diagnostic services provided by a Dentist or Physician other than practitioner providing the dental treatment.

6. Emergency (Palliative) Treatment

7. Oral Radiographs (X-rays)

    a. Complete series intraoral x-rays or panoramic film x-rays, limited to one (1) film every sixty (60) months; and

    b. Bitewing x-rays, limited to one (1) set every six (6) months.

C. Basic Services

1. Space Maintainers

    a. Covered when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars or deciduous molars and permanent first molars that have not or will not develop; and

    b. Includes coverage for recementation of Space Maintainer.

2. Amalgam Restorations (Metal Fillings)

3. Resin-Based Composite Restorations (White Fillings)

4. Crown Repairs – Recementation, restoration and pin retention

    Recementation that becomes necessary during the first twelve (12) months following insertion by the same Provider is considered to be a part of the original Benefit.

5. Prefabricated Stainless Steel Crowns

    a. Limited to Members under fifteen (15) years old; and

    b. Limited to one (1) per tooth every thirty-six (36) months.

D. Major Services

1. Endodontic (Pulpal) Therapy

    a. Only covered if performed after forty-five (45) days from a root canal, otherwise will be considered part of the root canal.

    b. Limited to primary incisor teeth for Members up to age six (6) and for primary molars and cuspids up to age eleven (11).

    c. Limited to one (1) per eligible tooth per lifetime.

2. Root Canal

3. Surgical Periodontics

    a. Gingivectomy or Gingivoplasty, limited to one (1) every thirty-six (36) months.

    b. Gingival flap procedure, limited to one (1) every thirty-six (36) months.

    c. Clinical crown lengthening.

    d. Osseous Surgery, limited to one (1) every thirty-six (36) months.

    e. Guided tissue regeneration, limited to one (1) per tooth per lifetime.

    f. Pedicle soft tissue graft, limited to one (1) every thirty-six (36) months.

    g. Free soft tissue graft.

    h. Subepithelial connective tissue graft.

    i. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to one (1) per lifetime.

4. Non-Surgical Periodontics

    Periodontal Scaling and Root Planing, limited to one (1) every twenty-four (24) months for each area of the mouth.

5. Periodontal Maintenance

    Limited to four (4) every twelve (12) months in addition to routine prophylaxis.

6. Simple Extractions

    Extraction of erupted tooth or exposed root.

7. Surgical Extractions

    Surgical removal of erupted tooth with elevation of mucoperiosteal flap and removal of bone and/or section of tooth.

8. Oral Surgery

    a. Removal of impacted tooth.

    b. Surgical removal of residual tooth roots.

c. Coronectomy-intentional partial tooth removal.

d. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.

e. Surgical access to an unerupted tooth.

f. Alveoloplasty.

g. Removal of exostosis.

h. Intraoral soft tissue incision and drainage of abscess.

i. Suture of recent small wounds.

j. Excision of pericoronal gingiva.

9. Anesthesia

   a. Anesthesia for dental services covered only when Dentally Necessary.

   b. Includes deep sedation/general anesthesia or intra-venous conscious sedation/analgesia.

   c. If the Member has a medical condition that requires dental services which would ordinarily be provided in a dental office to be performed in a Hospital setting, the anesthesia services will be covered exclusively under the medical coverage of this Benefit Plan and not under this pediatric dental Benefit.

10. Prosthetic Dentures

    a. Includes complete, fixed, removable or partial dentures.

    b. Limited to one (1) every sixty (60) months.

11. Inlays, Onlays and Crowns

    a. Crowns, Inlays, Onlays, core buildup including pins, and prefabricated post and core; and

    b. All limited to one (1) per tooth every sixty (60) months.

12. Adjustments, repairs, and replacement of Prosthetic Dentures

13. Other Prosthetic Services

    a. Rebase or reline of mandibular or maxillary complete or partial dentures, limited to one (1) every thirty-six (36) months. Covered only for six (6) months after the initial installation.

    b. Tissue conditioning.

    c. Recementation or repair of fixed partial denture.

       (1) Recementation during the first twelve (12) months following insertion from the same Dentist is included in the prosthetic service Benefit.

14. Dental Implants

    a. Implants must be Dentally Necessary and are covered only when the arch cannot be restored with a standard prosthesis or restoration.

    b. The following implant Benefits are limited to one (1) every sixty (60) months:

(1) endosteal, eposteal, and transosteal implants;

(2) connecting bar;

(3) prefabricated abutment;

(4) abutment supported Crowns;

(5) implant supported Crowns;

(6) abutment supported retainers for dentures;

(7) implant supported retainers for dentures;

(8) implant maintenance procedures;

(9) repair of implant prosthesis;

(10) replacement of semi-precision or precision attachment;

(11) repair of implant abutment;

(12) implant removal;

(13) implant index; and

(14) surgical placement of interim implant body.

c. Implant supported complete or partial dentures.

15. Occlusal Guard

a. Limited to one (1) every twelve (12) months; and

b. Limited to patients that are thirteen (13) years of age and older.

16. Adjunctive General Services

a. Therapeutic drug injection

b. Treatment of Complications from oral Surgery in unusual circumstances (for example, but not limited to, treatment of dry socket following extraction or removal of bony sequestrum).

E. Medically Necessary Orthodontics

Covered Benefits include services for limited, interceptive and comprehensive Orthodontic treatment of the primary, transitional and adolescent dentition in addition to removable and fixed appliance therapy. Treatment visits are provided for pre-Orthodontic, periodic Orthodontic and Orthodontic retention.

Orthodontic services will only be covered if the Member fits the following criteria:

1. Members must have a fully erupted set of permanent teeth to be eligible for comprehensive Orthodontic services.

2. **All Orthodontic services require Authorization,** a written plan of care, and must be rendered by a Provider.

3. Orthodontic treatment must be considered Medically Necessary and be the only method considered capable of:

a. Preventing irreversible damage to the Member's teeth or their supporting structures.

b. Restoring the Member's oral structure to health and function.

4. A Medically Necessary orthodontic service is an orthodontic procedure that occurs as a part of an approved orthodontic treatment plan that is intended to treat a severe dentofacial abnormality or serious handicapping malocclusion. **Orthodontic services for cosmetic purposes are not covered.**

5. Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the Member's physical health or for serious handicapping malocclusions. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite.

6. Dentofacial abnormalities that severely compromise the Member's physical health may be manifested by:

   a. Markedly protruding upper jaw and teeth, protruding lower jaw and teeth, or the protrusion of upper and lower teeth so that the lips cannot be brought together.

   b. Under-developed lower jaw and receding chin.

   c. Marked asymmetry of the lower face.

7. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:

   a. Obvious difficulty in eating because of the malocclusion, so as to require a liquid or semisoft diet, cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial muscles during eating because of necessary compensation for anatomic deviations.

   b. Obvious severe breathing difficulties related to the malocclusion, such as unusually long lower face with downward rotation of the mandible in which lips cannot be brought together, or chronic mouth breathing and postural abnormalities relating to breathing difficulties.

   c. Lisping or other speech articulation errors that are directly related to orofacial abnormalities and cannot be corrected by means other than Orthodontic intervention.

F. Pre-Determination

Pre-determination of dental Benefits is a service available through UCD. This Benefit review in advance of treatment enables You and Your Dentist to see what services are covered by the plan and what Your cost share and other costs would be.

Pre-determination should not be requested unless total charges for a proposed treatment plan exceed $200. You may ask Your Dentist to submit a pre-determination request. UCD will then provide a summary of covered expenses and payable amounts.

Please note that pre-determinations are not designed to be used for Emergency treatments or routine preventive services such as exams, x-rays or cleanings.

A pre-determination is not an Authorization. When a Covered Service needs to be Authorized, a formal Authorization request prior to service will have to be submitted.

G. Alternate Benefits

If UCD determines that a less costly Covered Service other than the Covered Service the Dentist performed could have been performed to treat a dental condition, We will pay Benefits based upon the less costly service if such service would produce a professionally acceptable result under generally accepted dental standards. If the Member and the Dentist choose the more expensive treatment, the Member will be responsible for the additional charges, beyond those allowed under this clause. This limitation does not apply to covered implantology services.

Alternate Benefits applicable to Your treatment plan will be determined during Authorization. However, should the services billed differ from those Authorized, UCD reserves the right to determine if an alternate Benefit is applicable to the actual services rendered.

H. Coordination of this Section with Stand-Alone Dental Contracts

If a Member has stand-alone coverage for dental Benefits that includes coverage for the Benefits provided for under this Benefit Plan, the dental Benefits under the stand-alone coverage will be determined first. Then, the Benefits under this section will be determined on a secondary basis and will be reduced, so that no more than the full amount of the Allowable Charge is paid under all the dental Benefits for the same Claim or service.

I. Benefit Extension Period After Termination of Coverage

1. The dental coverage under this section will be extended after the date the coverage for the Member terminates only if:

   a. A covered Benefit for such service was incurred while coverage was in effect; and

   b. Such covered Benefit is completed within thirty-one (31) days after coverage terminates.

2. A covered Benefit expense will be deemed incurred as follows:

   a. For appliances or changes to appliances – on the date the appliance or prosthesis is permanently placed;

   b. For Crowns, dentures or bridgework – on the date the impression is taken;

   c. For root canal therapy – on the date the pulp chamber is opened; or

   d. For all other dental expenses – on the date the service is rendered or the supply is furnished.

J. Exclusions

Only American Dental Association procedure codes are covered under this section. Except as specifically provided in this Benefit Plan and Schedule of Benefits, no coverage will be provided under this section for services, supplies or charges that are:

1. Started prior to the Member's Effective Date or after the termination date of coverage under this Benefit Plan including, but not limited to, multi-visit procedures such as endodontics, Crowns, bridges, Inlays, Onlays, and dentures.

2. For house or Hospital calls for dental services and for hospitalization costs (e.g., facility-use fees).

3. The responsibility of any federal or state workers' compensation laws and/or 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, the responsibility of employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. Benefits would be in excess to the third-party Benefits and therefore, We would have right of recovery for any Benefits paid in excess. Our right of subrogation is contingent on the right of the covered insured to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or a judgment following a trial.

4. Cosmetic in nature as determined by UCD (for example, but not limited to, bleaching, veneer facings, personalization or characterization of Crowns, bridges and/or dentures).

5. Maxillofacial prosthetics.

6. Elective procedures (for example, but not limited to, the prophylactic extraction of third molars).

7. For congenital mouth malformations or skeletal imbalances (for example, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic Surgery including Orthodontic treatment). Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies or Equipment Article of this plan.

8. For diagnostic services and treatment of jaw joint problems by any method unless specifically covered under this Benefit Plan. Examples of these jaw joint problems are Temporomandibular Joint (TMJ) Disorders or other conditions of the joint linking the jawbone and the complex oromandibular dystonia muscles, nerves and other tissues related to the joint.

9. For treatment of fractures and dislocations of the jaw.

10. For treatment of malignancies or neoplasms.

11. For services and/or appliances that alter the vertical dimension (for example, but not limited to, full-mouth rehabilitation, splinting, Fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

12. For replacement or repair of lost, stolen or damaged prosthetic or Orthodontic appliances.

13. For periodontal splinting of teeth by any method.

14. For duplicate dentures, prosthetic devices or any other duplicative device.

15. For which in the absence of insurance the Member would incur no charge.

16. For plaque control programs, oral hygiene and dietary instructions.

17. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

18. For treatment and appliances for bruxism (night grinding of teeth), with exception of an Occlusal Guard.

19. For any Claims submitted to the Company or UCD later than fifteen (15) months after the date of service.

20. For incomplete treatment (for example, but not limited to, patient does not return to complete treatment) and temporary services (for example, but not limited to, temporary restorations).

21. For procedures that are:

    a. part of a service but are reported as separate services; or

    b. reported in a treatment sequence that is not appropriate; or

    c. misreported or that represent a procedure other than the one reported.

22. For specialized procedures and techniques (for example, but not limited to, precision attachments, copings and intentional root canal treatment).

23. Fees for broken appointments.

24. Not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of UCD will apply.

25. Orthodontic treatment is not a Covered Service unless deemed Medically Necessary and a written treatment plan is approved by Us. Orthodontic services for the following are excluded:

    a. Treatments that are primarily for Cosmetic reasons.

b. Treatments for congenital mouth malformations or skeletal imbalances (e.g., treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic Surgery including orthodontic treatment). Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies or Equipment Article of this Benefit Plan.

c. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Schedule of Benefits. Examples of these jaw joint problems are Temporomandibular Joint (TMJ) Disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to the joint.

27. Posterior resin Fillings.

28. Administration of nitrous oxide.

ARTICLE XVI. PEDIATRIC VISION CARE BENEFITS

The vision Benefits described in this section are available for Members under the age of nineteen (19) only.

Members who attain age nineteen (19) during a Plan Year will continue to have these Benefits until the end of that Plan Year. Members that age off the coverage under this section may be eligible to purchase other vision coverage through Blue Cross and Blue Shield of Louisiana. Please contact a customer service representative for details. The Schedule of Benefits controls the Benefits covered, the frequency with which they are covered, and the cost sharing applicable to each Benefit. The Benefits offered are limited.

A. Definitions (Applicable only to this Pediatric Vision Care Benefits Article of this plan)

1. Bifocal Lenses – A lens containing two different powers: one for distance vision and one for near vision. Bifocal Lenses can be lined or unlined. Lined Bifocal Lenses are those in which both powers are easily distinguished by a line between them. Unlined Bifocal Lenses are those in which both powers are not easily distinguishable.

2. Blended-Segment Lenses – A lens containing two different powers, one for distance, and one for near. Segment with near prescription is invisible.

3. Company – HMO Louisiana, Inc. or Davis Vision, Inc. in regards to the services it renders on HMO Louisiana, Inc.'s behalf.

4. Contact Lenses – Devices that correct refractive errors in vision and are comprised of a small shell-like lens that is worn externally resting directly on the eye. To include soft lens, daily wear, disposable/planned replacement, extended wear, gas permeable, hard, Medically Necessary, monovision, scleral shell, and toric.

5. Digital Surface Technology Progressive Lenses – A lens that is designed to provide correction for more than one viewing range, in which the power changes continuously rather than discretely. The digital surfacing technology refers to a digital manufacturing technique that uses proprietary software to define a unique progressive lens fully customized to the wearer's prescription, fitting geometry and frame information before cutting this design into the lens.

6. Evaluation and Fitting – Means the professional individualized fitting of Contact Lenses and the professional evaluation to check that the prescription is correct and that there is no irritation of the eyes.

7. Eyeglass Frame – Plastic or metal structure for holding Spectacle Lenses.

8. Fashion Tinting – Tints that are used primarily for cosmetic purposes.

9. Glass-Grey #3 Prescription Sunglass Lenses – Glass lenses that turn grey when exposed to the sun's ultraviolet light.

10. Gradient Tinting – A Spectacle Lens coating that is darker at the top of the lens, fading to lighter at the bottom.

11. High-Index Lenses – Material that results in thinner (almost one-third) Spectacle Lenses than normal plastic. Does not contain the impact resistant qualities of polycarbonate.

12. Intermediate-Vision Lens – A Trifocal Lens or blank which has been designed to correct vision at ranges intermediate to distant and near objects.

13. Lenticular Lenses – A lens, usually of strong refractive power, in which the prescribed power is applied over only a limited central region of the lens, called the lenticular portion.

14. Medically Necessary Contact Lenses – Contact Lenses that are determined as Medically Necessary in the treatment of the following conditions: Keratoconus, Anisometropia, Corneal Disorders, Pathological Myopia, Aniseikonia, Post-Traumatic Disorders, Aphakia, Aniridia and Irregular Astigmatism. In general, Medically Necessary Contact Lenses may be prescribed in lieu of eyeglasses, when it will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

15. Monocular Patient – Refers to a patient who sees out of only one eye.

16. Oversize Lenses – A larger than standard lens type that requires special frames and equipment to fabricate the eyeglasses.

17. Pediatric Contact Lenses Selection or Selection Contact Lenses – A selection of Contact Lenses offered to Members by Davis Vision through Participating Providers.

18. Pediatric Eyeglass Frames Selection or Selection Frames – A selection of Eyeglass Frames offered to Members by Davis Vision thorough Participating Providers.

19. Photochromic Glass Lenses – Glass Spectacle Lenses that darken when exposed to the ultraviolet rays of the sun.

20. Plastic Photosensitive Lenses – Plastic lenses that darken when exposed to the sun's ultraviolet rays.

21. Polarized Lenses – Spectacle Lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.

22. Polycarbonate Lens – A Spectacle Lens made of a high impact-resistant material used for safety in children's eyewear, sports and other cosmetic purposes. Lenses are 20-25% thinner than regular plastic.

23. Premium Anti-Reflective Coating – A non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection with superior smudge resistance and optimum clean-ability, such as Crizal™ or equivalent. Advanced forms of Anti-Reflective Coatings for Spectacle Lenses with improved durability.

24. Premium Progressives Lenses – Lenses with continuously variable power zones from far distance to near distance correction with a newer, branded progressive lens design or a proprietary, digitally manufactured design. Lenses are often referred to as "free-form design" or "wave-front technology" to help minimize peripheral distortion.

25. Provider – An ophthalmologist, optometrist, optician, Physician, or legally authorized eyeglass and Contact Lens retail store, licensed where required, performing within the scope of license, and approved by the Company. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

    a. Participating Provider – A Provider that has a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member.

    b. Non-Participating Provider – A Provider that does not have a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member.

26. Routine Eye Health Examination – A level of service in which a general evaluation of the complete visual system of the human body is made. This includes:

    a. Case history (chief complaint, eye and vision history, medical history);

    b. Entrance distance and near acuities, with and without current lenses;

    c. External ocular evaluation;

    d. Internal ocular examination;

    e. Tonometry;

    f. Refraction (objective and subjective);

g. Binocular coordination and ocular motility evaluation;

h. Evaluation of pupillary function;

i. Biomicroscopy;

j. Gross visual fields;

k. Assessment and plan;

l. Advising the patient on matters pertaining to vision care;

m. Form completion (e.g., school, motor vehicle); and

n. A Dilated Fundus Examination (DFE) when professionally indicated (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systematic diseases).

27. Scratch Protection Plan – An optional plan that will replace scratched lenses with new lenses of the same material, style and prescription, at no charge for a period of one year from the original date of dispensing. A Scratch Protection Plan may be available for single vision lenses only, for multifocal vision lenses only, or for both.

28. Scratch-Resistant Coating – Coating applied to Spectacle Lenses to increase the scratch resistance of the lens surface.

29. Select Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with a newer, proprietary progressive lens design.

30. Specialty Type Contact Lenses – Contact Lenses that are newer in the market than Standard Type Contact Lenses and require a specialty fitting. These lens types include, but not limited to, toric, multifocal and gas permeable lenses.

31. Spectacle Lenses – Devices that correct refractive errors in vision which are intended to be mounted on Eyeglass Frames to be worn externally, involving a transparent medium bounded by two geometrically describable surfaces one of which shall be curved, that is, spherical, cylindrical, toroidal or aspheric.

32. Standard Anti-Reflective Coating – A non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection, such as Aegis™ Anti-Reflective Treatment or equivalent.

33. Standard Progressive Lenses – Lenses with variable power zones from far distance to near distance correction with an older, proven branded progressive lens design.

34. Standard Type Contact Lenses – Commonly used Contact Lens types defined as spherical clear Contact Lenses. These include disposable Contact Lenses planned replacement lenses and others.

35. Trifocal Lenses – A multifocal lens with three different powers in three different positions. Usually, the top (largest) portion is for distance vision, the middle portion is for intermediate distances and the bottom portion is for near vision. Trifocal Lenses can be lined or unlined. Lined Trifocal Lenses are those in which the different powers are easily distinguished by a line between them. Unlined Trifocal Lenses are those in which the different powers are not easily distinguishable.

36. Ultra Anti-Reflective Coating – Non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection. The ultra-coating uses the latest lens material technologies with all the Benefits of both standard and premium lenses.

37. Ultra Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with the newest branded progressive lens design technology, including a digitally manufactured design.

38. Ultraviolet Coating – A coating for Spectacle Lenses that blocks ultraviolet rays.

B. Vision Benefits

The Schedule of Benefits control how the Benefits described in this Article are covered under the Member's Benefit Plan, with what frequency, and what limitations apply to them. **Any vision Benefit listed in this Benefit Plan that is not mandated by state or federal law may be deleted or revised on the Schedule of Benefits.** Please refer to the Schedule of Benefits for details.

1. Network Benefits

   Subject to the specifications described on the Schedule of Benefits, each Member will have coverage for the following services, if received from Participating Providers:

   a. One (1) Routine Eye Health Examination

      The Company will cover one (1) Routine Eye Health Examination as stated on the Schedule of Benefits. Covered Routine Eye Health Examinations will include dilation of eye pupils when professionally indicated.

   b. Prescription Spectacle Lenses for each of the Member's Eyes

      The Company will cover one (1) prescription Spectacle Lens for each of the Member's eyes, as stated on the Schedule of Benefits. The Schedule of Benefits will explain if the Member has additional coverage for some special types of lens material and enhancements, and the Copayment that applies to each. Lens materials or enhancements not specifically mentioned on the Schedule of Benefits are not covered.

   c. Pediatric Eyeglass Frame Selection

      The Company will cover one (1) Selection Frame as stated on the Schedule of Benefits. Participating Providers will show the Member the selection of frames covered by this Benefit Plan. If the Member does not select a Selection Frame, the Member will be responsible for the difference in cost between the Selection and Non-Selection Frame. Any amount paid to the Provider for the difference in cost of a Non-Selection Frame is not covered and will not apply to any applicable Deductible Amount, Coinsurance, or Out-of-Pocket Amount. Any frame purchased from a Non-Participating Provider will be considered a Non-Selection Frame and will be subject to the Non-Network Benefit limitations.

   d. Prescription Pediatric Contact Lenses Selection

      The Company will cover Prescription Selection Contact Lenses, in lieu of eyeglasses, and up to the maximum of pairs or boxes for conventional or planned replacement Contact Lenses stated on the Schedule of Benefits. Participating Providers will inform the Member of the Contact Lenses selection covered by this Benefit Plan. If the Member chooses Non-Selection Contact Lenses, the Member will be responsible the difference in cost between the Selection and Non-Selection Contact Lenses. Any amount paid to the Provider for the difference in cost of a Non-Selection Contact Lens is not covered and will not apply to any applicable Deductible Amount, Coinsurance or Out-of-Pocket Amount. Any Contact Lens purchased from a Non-Participating Provider will be considered a Non-Selection Contact Lens, and coverage will be limited according to the Non-Network Benefit section.

   e. Low Vision Benefits

      Subject to prior Authorization, Members with Low Vision will receive the following:

      (1) One (1) comprehensive evaluation every five (5) years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print,

the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

(2) One (1) device per year such as high-power spectacles, magnifiers and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's visual goals and lifestyle needs.

(3) Four (4) follow-up visits in any five-year period.

C. Limitations to Network Benefits

1. Medically Necessary Contact Lenses

   Medically Necessary Contact Lenses are subject to Authorization. Medically Necessary Contact Lenses that are not duly Authorized will not be covered.

2. Selection and Non-Selection Eyeglass Frames

   Members may choose either one (1) Selection or one Non-Selection Eyeglass Frame within their frequency period, but not both.

3. Contact Lens Evaluation, Fitting and Follow-up Care

   Evaluation and Fitting services for Selection Contact Lenses and Medically Necessary Contact Lenses that are provided by a Participating Provider are covered. Follow-up services are covered up to one (1) visit only. Evaluation, Fitting and follow-up services for Non-Selection Contact Lenses are not covered.

D. Non-Network Benefits

This Benefit Plan does not provide coverage for services and materials rendered by Non-Participating Providers. Any charges billed by Non-Participating Providers for those services will not be covered and will be the responsibility of the Member.

E. Discounts

Members may have access to discounts on vision-related services and materials not covered under this Benefit Plan. Any discounts are administered and provided by Davis Vision in consideration of the Member being covered under this Benefit Plan. Discounts are not to be considered coverage under this Benefit Plan, unless stated otherwise in the materials describing the discount. Davis Vision may change or discontinue the discounts provided to their clients in the regular course of business. Members must consult with Davis Vision or a Davis Vision Provider to find out what discounts are available to them at any specific time.

F. Sales Taxes on Covered Items

Providers may be required in some areas to collect sales taxes over the value of covered items or services. In such cases, this coverage will not cover sales taxes. The Member must pay any sales taxes, in addition to non-covered amounts and discount priced items.

G. Exclusions

1. Implants, intacts or any kind of intraocular lenses.

2. Surgical treatments for vision correction, unless otherwise specifically covered under another part of this Benefit Plan.

3. Services or materials other than those specifically listed on the Schedule of Benefits for Vision Care and described under this part of this Benefit Plan.

4. Non-prescription eyewear or Contact Lenses.

5. Any sales taxes or interest.

ARTICLE XVII. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. Acupuncture Benefits

Benefits are available for acupuncture used in connection with medical treatment for cancer when services are Medically Necessary and provided in an Outpatient setting. Benefits are limited to fifteen (15) visits per Benefit Period received from In-Network or Out-of-Network Providers combined. All other subsequent acupuncture visits are not covered unless additional treatments used in connection with medical treatment for cancer are recommended by nationally recognized cancer guidelines and the treating Physician. Any additional acupuncture visits may be requested by use of the appeals process upon denial of an acupuncture benefit.

B. Ambulance Service Benefits

1. Ground Ambulance Transport Services

   a. Emergency Transport

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

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

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

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

   b. Non-Emergency Transport

      Benefits for Ambulance Services are available for local transportation of Members for non-Emergency medical conditions to obtain Medically Necessary Inpatient or Outpatient services when the Member is bed-confined, or the Member's condition does not allow the use of any other method of transportation. The term bed-confined is not synonymous with bed rest or non-ambulatory. Benefits for non-Emergency transport are only available for transport to or from the nearest facility or Hospital capable of providing the Medically Necessary services.

      To be considered bed-confined and to qualify for non-Emergency transport, the Member must be unable to do all of the following:

      (1) get up from bed without assistance;

      (2) walk or move about freely; and

      (3) sit in a chair or wheelchair.

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

2. Ground Ambulance without Transport

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

3. Air Ambulance Transport Services

   a. Emergency Transport

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

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

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

   b. Non-Emergency Transport

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

4. Ambulance Service Benefits will be provided as follows:

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

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

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

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

C. Attention Deficit/Hyperactivity Disorder

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

D. Autism Spectrum Disorders

Autism Spectrum Disorder 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 Disorder when it is determined to be Medically Necessary.

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

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

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

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

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

   c. Prostheses; and

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

   These Covered Services shall be delivered in a manner determined in consultation with the Member and the Member's attending Physician, if applicable, and will be subject to applicable cost share shown on the Schedule of Benefits.

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

   a. were previously diagnosed with breast cancer;

   b. completed treatment for breast cancer;

   c. underwent bilateral mastectomy; and

   d. were subsequently determined to be clear of cancer.

   These Covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with the attending Physician and Member. Annual preventive cancer screenings under this Benefit are subject to applicable cost share shown on the Schedule of Benefits.

F. Cleft Lip and Cleft Palate Services

Covered Services include the following:

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. The preventive and restorative dentistry services must not be more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies and must be as likely to produce equivalent therapeutic or diagnostic results for diagnosing or treating the patient's condition.

5. Speech/Language evaluation and therapy;

6. Audiological assessments and amplification devices;

7. Otolaryngology treatment and management;

8. Psychological assessment and counseling; and

9. Genetic assessment and counseling for patient and parents.

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

G. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with 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 applicable cost share shown on the Schedule of Benefits.

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

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

   b. And either,

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

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

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

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

      (1) The National Institutes of Health.

      (2) The Centers for Disease Control and Prevention.

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

      (4) The Centers for Medicare & Medicaid Services.

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

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

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

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

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

(1) The Department of Veterans Affairs.

(2) The Department of Defense.

(3) The Department of Energy.

4. The following services are not covered:

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

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

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

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

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

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

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

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

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

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

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

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

H. Dental Treatment for Cancer Patients

Benefits are available for dental treatments for Members diagnosed with cancer and scheduled to undergo cancer treatment. These treatments include evaluation, imaging, clinical examination, and dental extractions. These treatments must be Medically Necessary to reduce the risk of infection, eliminate infection, or treat tooth loss or decay as part of a pre-cancer treatment screening for a person who has been diagnosed with cancer. Routine preventive dental care, including, but not limited to, cleaning and sealants, are not covered as part of the Dental Services for Cancer Patients Benefits. These covered dental services are distinct from and do not include services for head and neck cancer patients provided under the Oral Surgery Benefits Article.

I. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

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

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

      (1) The program must be prescribed by Member's treating Provider and provided by a licensed healthcare professional who certifies that the Member has successfully completed the training program.

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

2. Diabetic Retinal Screening

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

J. Dietitian Visits for Nutritional Counseling

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

K. Disposable Medical Equipment and Supplies

Disposable medical equipment and supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by Us. The equipment and supplies are subject to the Member's applicable medical cost share shown on the Schedule of Benefits.

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

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

Durable Medical Equipment, Orthotic Devices and Non-Limb Prosthetic Appliances and Devices and Prosthetic Services are subject to an aggregate Benefit Period maximum, if shown on the Schedule of Benefits. Prosthetic Appliances and Devices of the limbs and Prosthetic Services of the limbs accrue to the Benefit Period maximum for each limb, shown on the Schedule of Benefits.

1. Durable Medical Equipment

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

      (1) It must withstand repeated use;

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

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

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

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

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

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

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

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

(a) that do not serve a medical purpose;

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

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

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

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

(5) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement due to loss, theft, negligent care, avoidable damage, intentional damage, abuse, neglect, or destruction is not covered. We also will not cover replacement in cases where the Member sells or gives away the equipment. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Contract, will not be covered.

c. Limitations in connection with Durable Medical Equipment.

(1) Regardless of Medical Necessity, 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) Regardless of Medical Necessity, there is no coverage for replacement of equipment due to loss, theft, negligent care, avoidable damage, intentional damage, abuse, neglect, or destruction.

(4) Regardless of Medical Necessity, there is no coverage for replacement of equipment in cases where the Member sells or gives away the equipment.

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

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

(7) 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.

(8) Regardless of Medical Necessity, repair, adjustment, or replacement of equipment will not be covered when provided under warranty.

2. Orthotic Devices

Orthotic Devices are covered when Authorized by Us, subject to the following.

a. Primary Orthotic Devices

(1) A primary Orthotic Device is covered.

(2) When a primary Orthotic Device is approved by Us, Benefits for a standard device will be provided toward any deluxe device.

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

(i) that do not serve a medical purpose;

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

(iii) that are solely for Your comfort or convenience; or

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

(b) Regardless of Claim of Medical Necessity, Deluxe primary Orthotic Devices or deluxe features and functionalities of primary Orthotic Devices that are not approved by Us are not covered.

b. Additional Orthotic Devices for Upper or Lower Limbs

(1) A second Orthotic Device for upper or low limbs only is covered as set forth below.

(a) In addition to a primary Orthotic Device for upper or lower limbs, a second Orthotic Device for upper or lower limbs is provided when the additional Orthotic Device permits the Member to engage in physical activities, such as running, biking, swimming, or strength training.

(b) This coverage is subject to Our determination that it is the most appropriate device to meet the Member's medical needs for purposes of performing physical activities and to maximize the Member's whole-body health and/or lower and upper limb function.

(2) A third Orthotic Device for upper or low limbs is covered in addition to the primary and secondary Orthotic Devices for upper and lower limbs when the third Orthotic Device enables the Member to safely engage in bathing and showering.

(3) Coverage for additional second or third Orthotic Devices for upper or lower limbs are subject to the following limitations.

(a) When two or more devices can serve the same purpose of the second or third Orthotic Device for upper or lower limbs, coverage is limited to the least costly device.

(b) If the Member elects a more expensive additional Orthotic Device, the Member will be responsible for any difference in cost.

(c) This coverage is subject to Our determination that it is the most appropriate additional Orthotic Device to meet the Member's medical needs for purposes of performing physical activities and to maximize the Member's whole-body health and/or lower and upper limb function.

(d) Orthotic Devices of the Limbs 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) or they are not covered.

(e) Coverage for any second or third Orthotic Devices of the Limbs may be subject to any limitations on the number of Orthotic Devices of the Limbs covered during a Member's lifetime or within a specified period or any other quantity or frequency limits permitted by applicable law. This limit is in addition to any other limitations set forth above.

c. Limitations applicable to all Orthotic Devices:

(1) Regardless of Medical Necessity, there is no coverage for fitting or adjustments for any Orthotic Device as this is included in the Allowable Charge for the Orthotic Device.

(2) Repair or replacement of any Orthotic Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the Orthotic Device. We will determine this time-period.

(3) Regardless of Medical Necessity, repair or replacement of any Orthotic Device will not be covered when provided under warranty or when the Orthotic Device is subject to a recall.

(4) Regardless of Medical Necessity, there is no coverage for repair or replacement of an Orthotic Device due to loss, theft, negligent care, avoidable damage, intentional damage, abuse, neglect, or destruction.

(5) Regardless of Medical Necessity, there is no coverage for replacement of an Orthotic Device in cases where the Member sells or gives away the Orthotic Device.

(6) Reasonable quantity limits on Orthotic Devices will be determined by Us.

(7) 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) when Authorized by Us, subject to the following.

a. Regardless of Medical Necessity, there is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.

b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance or device. We will determine this time-period.

c. 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.

d. Regardless of Medical Necessity, repair or replacement of appliances or devices will not be covered when due to loss, theft, negligent care, avoidable damage, intentional damage, abuse, neglect, or destruction. We also will not cover replacement in cases where the Member sells or gives away the appliance or device.

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

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

(a) that do not serve a medical purpose;

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

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

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

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

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

Prosthetic Appliances and Devices of the Limbs and Prosthetic Services of the Limbs are covered when Authorized by Us, subject to the following.

a. Primary Prosthetic Appliances and Devices of the Limbs

(1) A primary Prosthetic Appliances and Devices of the Limbs is covered.

(2) When a Prosthetic Appliance or Device of the Limbs is approved by Us, Benefits for a standard appliance or device will be provided toward any deluxe appliance or device.

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

(i) that do not serve a medical purpose;

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

(iii) that are solely for Your comfort or convenience; or

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

(b) Regardless of Claim of Medical Necessity, deluxe primary Prosthetic Appliances or Devices of the Limbs or deluxe features and functionalities of primary Prosthetic Appliances or Devices of the Limbs that are not approved by Us are not covered.

b. Additional Prosthetic Appliances or Devices of the Upper or Lower Limbs

(1) A second Prosthetic Appliances or Devices of the Upper or Lower Limbs is covered as set forth below.

(a) In addition to a primary Prosthetic Appliance or Device for upper or lower limbs, a second Prosthetic Appliance or Devices for upper or lower limbs is provided when the additional Prosthetic Appliances or Devices of the Limbs permits the Member to engage in physical activities, such as running, biking, swimming, or strength training.

(b) This coverage is subject to Our determination that it is the most appropriate appliance or device to meet the Member's medical needs for purposes of performing physical activities and to maximize the Member's whole-body health and/or lower and upper limb function.

(2) A third Prosthetic Appliances or Devices for upper or lower limbs is covered in addition to the primary and secondary Prosthetic Appliances or Devices for upper and lower limbs when the third Prosthetic Appliance or Device of the Limbs enables the Member to safely engage in bathing and showering.

(3) Coverage for additional Prosthetic Appliances or Devices for upper or lower limbs are subject to the following limitations.

(a) When two or more appliances or devices can serve the same purpose of the second or third Prosthetic Appliances or Devices of the Limbs, coverage is limited to the least costly appliance or device.

(b) If the Member elects a more expensive additional Prosthetic Appliances or Devices of the Limbs, the Member will be responsible for any difference in cost.

(c) This coverage is subject to Our determination that it is the most appropriate additional Prosthetic Appliance or Device of the Limbs to meet the Member's medical needs for purposes of performing physical activities and to maximize the Member's whole-body health and/or lower and upper limb function.

(d) Coverage for any second or third Prosthetic Appliances or Devices of the Limbs may be subject to any limitations on the number of prosthetic devices covered during a member's lifetime or within a specified period or any other quantity or frequency limits permitted by applicable law. This limit is in addition to any other limitations set forth above.

c. Limitations applicable to all Prosthetic Appliances or Devices of the Limbs:

(1) Regardless of Medical Necessity, there is no coverage for fitting or adjustments for any Prosthetic Appliances or Devices of the Limbs as this is included in the Allowable Charge for the Prosthetic Appliances or Devices of the Limbs.

(2) Repair or replacement of any Prosthetic Appliances or Devices of the Limbs is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the Prosthetic Appliances or Devices of the Limbs. We will determine this time-period.

(3) Regardless of Medical Necessity, repair or replacement of any Prosthetic Appliance or Device of the Limbs will not be covered when provided under warranty or when the Prosthetic Appliances or Devices of the Limbs is subject to a recall.

(4) Regardless of Medical Necessity, there is no coverage for repair or replacement of any Prosthetic Appliance or Device of the Limbs due to loss, theft, negligent care, avoidable damage, intentional damage, abuse, neglect, or destruction.

(5) Regardless of Medical Necessity, there is no coverage for replacement of any Prosthetic Appliance or Device of the Limbs in cases where the Member sells or gives away the Prosthetic Appliance or Device of the Limbs.

(6) Reasonable quantity limits on Prosthetic Appliances or Devices of the Limbs items and supplies will be determined by Us.

(7) Prosthetic Appliances and Devices of the Limbs 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) or they are not covered.

M. Emergency Medical Services

1. Hospital or Facility Services

a. If shown on the Schedule of Benefits, an Emergency Medical Services Copayment applies to each visit to a Hospital or facility for treatment of an Emergency Medical Condition. The Emergency Medical Services Copayment is waived if the visit results in an Inpatient Hospital Admission.

b. If an Emergency Medical Services Copayment is not shown on the Schedule of Benefits, applicable cost share shown on the Schedule of Benefits applies to each visit to a Hospital or facility for treatment of an Emergency Medical Condition.

2. Professional or Physician Services

Benefits for Professional or Physician services rendered for Emergency Medical Services will be subject to applicable cost share shown on the Schedule of Benefits.

N. Fertility Preservation Services

Medically Necessary standard fertility preservation services received from a Network Provider are covered for a Member receiving Medically Necessary treatment that will result in Iatrogenic Infertility.

Standard fertility preservation services cover extraction (including drugs for extraction obtained under the medical Benefit), cryopreservation, and up to three (3) years of storage of oocytes and sperm.

Benefits for fertility preservation services are subject to a lifetime maximum of $10,000 or three (3) years of storage costs, whichever is less. Benefits will not be provided beyond three (3) years even if the $10,000 lifetime maximum has not been met. This Benefit is subject to payment of applicable cost share shown on the Schedule of Benefits and that cost share will apply to the $10,000 lifetime maximum.

O. Gene Therapy and Cellular Immunotherapy Benefits

Gene Therapy and Cellular Immunotherapy are high cost, specialized treatments administered by a limited number of trained and quality Providers. Benefits are available for these services only:

1. WHEN WRITTEN AUTHORIZATION OF MEDICAL NECESSITY IS GIVEN BY THE COMPANY PRIOR TO SERVICES BEING PERFORMED; AND

2. SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM THE COMPANY TO PERFORM YOUR PROCEDURE.

P. Genetic or Molecular Testing for Cancer

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

Q. Hearing Benefits

1. Hearing Benefits for Members age 17 and under

   Benefits are available for hearing aids for covered Members 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 a licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

   This Benefit is subject to payment of applicable cost share shown on the Schedule of Benefits .

2. Hearing Benefits for Members age 18 and older

   Benefits are available for hearing aids for covered Members 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 a pure tone average air conduction threshold of 71dB or higher measured at 0.5, 1, 2, and 3 kilohertz (kHz). This Benefit is limited to one (1) hearing aid for each ear with severe hearing loss or profound hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate for the Member.

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

Authorization must be obtained prior to receiving a hearing aid for Members who are age eighteen (18) and older. This Benefit is subject to Medical Necessity and payment of applicable cost share shown on the Schedule of Benefits.

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

   Benefits are available for Medically Necessary cochlear implants and bone anchored hearing aids (BAHA) for all eligible Members, regardless of age, the same as any other service or supply.

   This Benefit is subject to Medical Necessity and payment of applicable cost share shown on the Schedule of Benefits.

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

   Benefits for hearing aids, assistive listening devices, or other hearing 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 Member's hearing loss.

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

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

R. High-Tech Imaging Services

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

S. Home Health Care

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

T. Home Visiting Services for Newborns and Young Children

Benefits are available for voluntary Home Visiting Services rendered by Providers approved by Us to deliver Home Visiting Services. Coverage for Home Visiting Services is limited to services for Members under age three (3) and services are limited to a maximum of five (5) visits total per lifetime per child.

U. Hospice Care

Hospice Care is covered and includes, but is not limited to, palliative care.

V. Integrative Cancer Treatments – Cryotherapy and Scalp Cooling

Benefits are available for cryotherapy and scalp cooling prescribed by the treating Physician for cancer when such treatments are Medically Necessary and recommended by nationally recognized cancer treatment guidelines.

Cryotherapy is limited to reimbursement for one (1) set of booties and one (1) set of mittens up to a lifetime maximum of forty dollars ($40) when obtained from an In-Network Provider or an Out-of-Network Provider and rendered in an Outpatient setting.

Scalp cooling system services are limited to reimbursement up to one thousand seven hundred fifty dollars ($1,750) per lifetime for services obtained from an In-Network Provider or Out-of-Network Provider and rendered in an Outpatient setting. Currently, scalp cooling services are only recommended for patients with breast cancer or ovarian cancer.

W. Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter or transliterator are covered when You need 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 Your 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.

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

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

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

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

Y. Lymphedema Benefit

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

Z. Out-of-Area Emergency Medical Services

1. If shown on the Schedule of Benefits, an Emergency Medical Services Copayment applies to each visit to a Hospital or facility for treatment of an Emergency Medical Condition. The Emergency Medical Services Copayment is waived if the visit results in an Inpatient Hospital Admission.

2. If an Emergency Medical Services Copayment is not shown on the Schedule of Benefits, applicable cost share shown on the Schedule of Benefits applies to each visit to a Hospital or facility for treatment of an Emergency Medical Condition.

Benefits for Professional or Physician services rendered for Emergency Medical Services will be subject to applicable cost share shown on the Schedule of Benefits.

AA. Permanent Sterilization Procedures

The following Surgical procedures that result in permanent sterilization are covered as stated herein:

1. Vasectomy is covered, unless shown as not covered on the Schedule of Benefits, but is not a Preventive or Wellness Care Benefit.

2. Tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes are covered as a Preventive or Wellness Care Benefit at no cost to Members when Covered Services are provided by a Network Provider.

BB. 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.

CC. 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.

DD. Private Duty Nursing Services

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

2. Private Duty Nursing Services are subject to applicable cost share shown on the Schedule of Benefits.

3. Inpatient Private Duty Nursing Services are not covered.

4. Your Benefit Plan limits coverage for Private Duty Nursing Services to three hundred (300) hours per Benefit Period.

EE. Sleep Studies

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

FF. Telehealth Services and Remote Patient Therapy Services

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

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

Telehealth Services generally must be held in real time by two-way video and audio transmissions simultaneously

(Synchronous). Telehealth Services does not cover telephone calls, and only when approved by Us is it allowed by methods other than simultaneous audio and video transmission.

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

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

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

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

GG. Treatment of the Foot

Benefits for a total of six (6) services, treatments or procedures for cutting or removal of corns and calluses are covered. Benefits for a total of six (6) services, treatments, or procedures for nail trimming and/or debridement are also covered. Benefits are limited for these services, treatments, or procedures per Benefit Period whether such services, treatments, or procedures are provided by Network Providers or Non-Network Providers. All other services, treatments, or procedures in excess of the limits are not covered. The Member must pay applicable cost share shown on the Schedule of Benefits.

HH. Urgent Care Center

Benefits are available for Urgent Care at an Urgent Care Center. The Member must pay applicable cost share shown on the Schedule of Benefits.

II. Urinary or Sexual Dysfunction Resulting from Cancer or Cancer Treatment

1. Coverage for the following treatments, procedures, and services to correct urinary or sexual dysfunction resulting from cancer or cancer treatments is available:

    a. Surgical treatment (including penile implants).

        (1) These Surgical treatments require prior Authorization, as shown on the Schedule of Benefits.

        (2) Coverage for penile implants is limited to one (1) per lifetime.

(3) Coverage for treatment (i.e., removal, repair, re-implantation) resulting from Complications of the one (1) covered penile implant is subject to Medical Necessity.

b. Coverage is available for provision of vacuum assisted devices (male vacuum erection system) 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.

c. Coverage is available for penile injections.

2. Sex therapy for treatment of sexual dysfunction is not covered.

ARTICLE XVIII. CARE MANAGEMENT

For a list of items and services that require Authorization, visit the website, **www.lablue.com/priorauth**.

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

1. Authorization and Selection of Provider

   Benefits will be paid at the highest Network level when care is received from a Network Provider. Participating and Non-Participating Providers are Non-Network Providers.

   a. If a Member wants to receive services from a Non-Network Provider and obtain Network Benefits, the Member must notify Our care management department before services are rendered. We will approve the use of a Non-Network Provider only if We determine that the services **cannot** be provided by a Network Provider within a seventy-five (75) mile radius of the Member'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.

   b. A request will not be approved for a Non-Network Provider outside the seventy-five (75) mile radius if there is a Network Provider who can perform the same or other appropriate Medically Necessary services to diagnose or treat the Member within the distance the Member is willing to travel to receive care from the proposed Non-Network Provider, no matter how many miles that may be. For example, if the proposed Non-Network Provider is located one hundred (100) miles away and there is a Network Provider capable of providing the same or other appropriate Medically Necessary services to diagnose or treat the individual one hundred (100) miles away or less, the approval will not be granted for the Non-Network Provider.

   c. 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.

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

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

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

   If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies requiring an Authorization, We will have the right to determine if the Admission or other Covered Services and supplies were Medically Necessary.

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

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

a. Admissions

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

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

b. Outpatient Services, Including Other Covered Services and Supplies

(1) If a Network Provider fails to obtain a required Authorization, We may reduce the Allowable Charge by the penalty stipulated in the Provider's contract. This penalty applies to all Outpatient services and supplies requiring an Authorization. The Network Provider is responsible for all charges not covered. The Member remains responsible for applicable cost share shown on the Schedule of Benefits.

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

3. Authorization of Admissions

a. Authorization of Elective Admissions

The Member is responsible for ensuring that the Provider notifies Our care management department of any Elective or non-Emergency Inpatient Hospital Admission. 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 care, or follow the instructions in the Provider Manual, if available to the Provider or facility. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.

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

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

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

b. Authorization of Emergency Admissions

It is the Member's responsibility to ensure that the Physician or Hospital, or a representative thereof, notifies the 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 number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or facility. We may waive or extend this time limitation if We determine that the Member is unable to timely

notify or direct a 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 Member must pay all charges incurred during the Admission.

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

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

c. Concurrent Review

When We Authorize a Member's Inpatient stay, We will Authorize the stay in the Hospital for a certain number of days. If the Member has not been discharged on or before the last Authorized day, and the Member needs additional days to be Authorized, the Member must make sure 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 Member's last Authorized day so We can review and respond to the request that day. If We Authorize the request, We will again Authorize a certain number of days, repeating this procedure until the Member is either discharged or the Member's continued stay request is denied. To request Concurrent Review for Authorization of additional day, 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 or facility.

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

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

(3) Charges for non-Authorized days in the Hospital that the Member must pay are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

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

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

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

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

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

5. Cancer Patient's Right to Prompt Coverage Act

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

6. Utilization Review Standards Required by Louisiana Law

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

B. Disease Management

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

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

C. Case Management

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

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

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

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

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

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

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

D. Alternative Benefits

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

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

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

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

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

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

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

ARTICLE XIX. LIMITATIONS AND EXCLUSIONS

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

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

C. **ANY LIMITATION OR EXCLUSION LISTED IN THIS BENEFIT PLAN MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT**.

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

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

2. Any charges exceeding the Allowable Charge.

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

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

   a. other than those specifically listed as covered by this Benefit Plan. Benefits are not payable for services a Member has no obligation to pay, or for which no charge or a lesser charge would be made if a Member had no health insurance coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions.

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

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

   d. to the extent payment has been made or is available under any other contract issued by HMO Louisiana, Inc. or any Blue Cross or 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 Member has Medicare, except when Medicare Secondary Payer provisions apply;

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

   g. rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes whether or not coverage under such laws or programs is actually in force. This exclusion shall not apply to services rendered to a Member holding ten (10%) percent or more ownership in the Group, if the Member has done all of the following:

(1) legally opted to be excluded from workers' compensation coverage for the Group by entering into a written agreement with Group's workers' compensation carrier electing not to be covered by such coverage;

(2) properly enrolled with the Company in owner twenty-four (24) hour health coverage;

(3) furnished the Company with a copy of the written agreement between the Member and the workers' compensation carrier; and

(4) furnished the Company with written evidence of Member's ownership interest in Group.

If this information is not submitted to the Company at the time of Member's initial enrollment for health coverage, or upon acquisition of the required ownership percentage, then Member may enroll for this coverage at Member's next open enrollment opportunity.

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

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

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

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

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

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

n. for 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 Member's commission or attempted commission of a felony; or

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

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

a. rhinoplasty;

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

c. gynecomastia;

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

e. breast reconstruction services (of either breast) when the underlying mastectomy is not covered, including prophylactic mastectomy procedures that do not satisfy the coverage criteria;

f. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, Complications and/or treatment in relation to or as a result of breast implants, except for breast reconstructive services as specifically provided in this Benefit Plan. When a medically necessary mastectomy is otherwise covered under this Benefit Plan, removal of breast implants that were originally implanted during a Cosmetic Surgery and/or for cosmetic purposes is only covered when removal constitutes an incidental service under the Medical and Surgical Benefits Article of this Benefit Plan. As an incidental service, the removal of breast implants, capsulectomy, and other services, treatments, or procedures determined by Us to be an incidental service may not be billed separately.

g. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, Complications and/or treatment in relation to or as a result of penile prosthesis (except for treatment provided under the Urinary Dysfunction or Sexual Dysfunction Resulting from Cancer or Cancer Treatment Benefit);

h. diastasis recti;

i. biofeedback, except that this exclusion shall not apply to neurofeedback services for the treatment of persons with acquired brain injuries that are deemed by Us to be Covered Services;

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

k. wilderness camp/programs except when provided by a qualified Residential Treatment Center and approved by Us as Medically Necessary for the treatment of Mental Health or substance use disorders;

l. treatment related to Erectile Dysfunction or sexual dysfunctions (except for those provided under the Urinary or Sexual Dysfunction Resulting from Cancer or Cancer Treatment Benefit), low sexual desire disorder or other sexual inadequacies;

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

n. recreational therapy, including, but not limited to, providing treatment, services and recreation activities using a variety of techniques including arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings;

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 Benefits section), eyeglasses or contact lenses (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered on the Schedule of Benefits;

b. eye exercises, visual training, or orthoptics;

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

d. hair pieces, wigs, hair growth, and/or hair implants;
e. the correction of refractive errors of the eye including, but not limited to, radial keratotomy and laser Surgery; or

f. visual therapy.

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

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

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

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

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

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

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

11. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products or prescription donor human breast milk as described in this Benefit Plan.

12. Benefits are excluded for Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered on the Schedule of Benefits:

a. lifestyle-enhancing drugs including, but not limited to, medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), medications used to enhance athletic performance, medications used for effects of aging on the skin, and medications used for hair loss or restoration (e.g., Propecia®, Rogaine®), except for Prescription Drugs approved by Us to treat alopecia areata or alopecia universalis;

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

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

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

e. fertility drugs are excluded, unless covered under the Fertility Preservation Services Section of this Benefit Plan;

f. nutritional or dietary supplements, or herbal supplements and treatments, except those required to be covered by the United States Preventive Services Task Force preventive services recommendations. Low Protein Food Products and prescription donor human breast milk are covered as described in this Benefit Plan;

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

h. drugs that can be lawfully obtained without a Physician's order or that do not require a prescription, including over-the-counter (OTC) drugs, except those required to be covered by law;

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

j. refills in excess of the number specified by the Physician or the dispensing limitation described in this Benefit Plan, or a refill prior to seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription;

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

   (1) are similar to a commercially available product;

   (2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval;

   (3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being administered topically);

   (4) compounded drugs that contain drug products or components of such drug products that have been withdrawn or removed from the market for reasons of safety; or

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

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

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

n. Prescription Drug compounding kits are excluded;

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

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

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

r. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;

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

t. Prescription Drugs or substances to treat sexual or Erectile Dysfunction (e.g., Viagra®, Cialis®, Levitra®), low sexual desire disorder (Addyi®) or other sexual inadequacies;

u. Equipment to treat sexual dysfunction or Erectile Dysfunction (except for equipment provided under the Urinary or Sexual Dysfunction Resulting from Cancer or Cancer Treatment Benefit), low sexual desire disorder, or other sexual inadequacies;

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

w. growth hormone therapy, except for the treatment of chronic renal insufficiency, AIDS wasting, Turner's Syndrome, Prader-Willi Syndrome, Noonan Syndrome, wound healing in burn patients, growth delay in patients with severe burns, short bowel syndrome, short stature homeobox-containing gene (SHOX) deficiency, or growth hormone deficiency when a Physician confirms the growth hormone deficiency with abnormal provocative stimulation testing;

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

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

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

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

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

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

dd. sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Member's Coinsurance and Our financial responsibility. We will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug cost is less than the Member's Copayment, in which case, the Member must pay the Prescription Drug cost and sales tax.

13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Acthar® (the Brand-Name Drug and any generic equivalent) is excluded under Pharmacy Benefits and medical Benefits, except when the drug is Medically Necessary to treat children less than age two (2) for infantile spasms.

14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to a Member's home or vehicle.

15. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for comfort or cosmetic care or treatment of the foot; supportive devices of the foot; and treatment of flat feet, except for Medically Necessary Surgery.

16. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for routine foot care, except as specifically provided in this Benefit Plan.

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

18. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits. This exclusion shall not apply to services covered under the Fertility Preservation Services section of this plan.

19. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, supplies or treatment related to artificial means of pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. This exclusion shall not apply to services covered under the Fertility Preservation Services section of this plan.

20. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.

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

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

23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Dental Care and Treatment except as specifically provided in this Benefit Plan under Dental Treatment for Cancer Patients, Oral Surgery Benefits, Pediatric Dental Care Benefits, and Cleft Lip and Cleft Palate Services.

24. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for dental implants and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits, Pediatric Dental Care Benefits, and Cleft Lip and Cleft Palate Services.

25. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for diagnosis, treatment, or Surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular Joint (TMJ) Disorders, hyperplasia or hypoplasia of the mandible and/or maxilla and any orthognathic condition. This exclusion does not apply to Cleft Lip and Cleft Palate Services.

26. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations,

including occupational, recreational, sports, travel and/or camp or school required examinations and immunizations, except as specifically provided in this Benefit Plan or to the extent the examination or immunization is Preventive or Wellness Care required by the Patient Protection and Affordable Care Act.

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

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

29. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This includes services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This includes Applied Behavior Analysis services that are not habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or Custodial Care to support academic learning opportunities in a classroom setting. Coverage is provided only if the services are provided in the most medically appropriate setting. Coverage will only be available for the least costly Medically Necessary service option. This exclusion for educational services and supplies does not apply to training and education for diabetes or for any Preventive or Wellness Care required by the Patient Protection and Affordable Care Act when the recommendation includes training and education.

30. Benefits are excluded for Applied Behavior Analysis that the Company has determined is not Medically Necessary. 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, is also excluded. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

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

32. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Custodial Care, nursing home care, assisted living facility care or custodial home care, regardless of the level of care required or provided. This exclusion for Custodial Care does not apply to Habilitative Care services 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.

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

34. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, 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.

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

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

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

38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a covered Member related to:

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

    b. Pre-implantation genetic diagnosis;

    c. Preconception carrier screening; and

    d. Prenatal carrier screening except screenings for cystic fibrosis.

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

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

41. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Mental Health services or substance use disorder services delivered through the Psychiatric Collaborative Care Model when used to treat a condition other than an approved behavioral health diagnosis.

42. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Virtual reality services, supplies, technologies, treatment, devices, or expenses related thereto no matter the setting in which virtual reality is used, including, but not limited to, Surgery.

43. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any complementary or alternative medicine treatments, therapies, practices, or supplements, including, but not limited to, aromatherapy; art therapy; ear candling; hypnosis; magnet therapy; rolfing; and other forms of complementary and alternative medicine as defined by the National Center for Complementary and Integrative Health (NCCIH)), unless specifically required by state law to be covered as integrative cancer treatments in the Other Covered Services, Supplies or Equipment Article.

ARTICLE XX. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

1. If eligibility for Group coverage ceases upon the death of the Subscriber, a surviving Spouse covered as a Dependent who is fifty (50) years of age or older, has ninety (90) days from the date of the Subscriber's death to notify the Company of the election to continue the same coverage, and if already covered, for any Dependents.

    a. Coverage is automatic during the ninety (90) day election period. Premium is owed for this coverage. If continuation is not chosen, or if premium is not received for the ninety (90) days of automatic coverage, the ninety (90) days of automatic coverage is terminated retroactive to the end of the billing cycle in which the death occurred.

    b. If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Premium is owed from the last date for which premium has been paid. No physical exams are required. Premium for continuing coverage will not exceed the premium assessed for each Subscriber by class of coverage under the Group Benefit Plan.

2. The Group will be responsible for notifying the Spouse of the right to continue and for billing and collection of premium. However, if We have been furnished with the home address of the surviving Spouse at the time of death and have been notified by the Group in an acceptable manner of the death of the Subscriber, We will notify the surviving Spouse of the right to continue. The Group will remain responsible for billing and collection of premium.

3. Coverage continues, as long as premium is paid timely, until the earliest of:

    a. the date premium is due and is not paid on a timely basis;

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

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

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

    e. the date this Group Benefit Plan ends; or

    f. the date a Dependent is no longer eligible.

B. State Continuation

State Continuation is available only if the Group is not subject to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto. The Subscriber or the 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.

1. A Subscriber or a Dependent may be entitled to continue the coverage under this Benefit Plan when eligibility for coverage ends because of:

    a. the death of the Subscriber;

    b. the termination of the Subscriber’s active employment; or

    c. the divorce of the Subscriber

2. Continuation of coverage for a Subscriber or a Dependent is **not** available if:

a. within thirty-one (31) days of termination of coverage, the Subscriber or the Dependent is or could have been covered by other group coverage or a government-sponsored health plan such as Medicare or Medicaid;

b. the coverage under this Benefit Plan terminated due to fraud or the failure to pay any required contribution to premium; or

c. the Subscriber or the Dependent is eligible for continuation of coverage under COBRA.

To elect continuation of coverage under this section, the Subscriber or the must notify the Group in writing of the election to continue this Benefit Plan 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 that made the Subscriber or the Dependent eligible. If a 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.

3. Continuation of insurance under the Group Benefit Plan for any Subscriber or Dependent shall terminate on the earliest of the following dates:

a. twelve (12) calendar months from the date coverage would have otherwise ended;

b. the date ending the period for which the Subscriber or the Dependent makes the last required premium contribution for the coverage; or

c. the date the Subscriber or the 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;

d. the date on which the Group terminates this Benefit Plan; or

e. the date on which an enrolled Subscriber or Dependent of a health maintenance organization legally resides outside the Service Area of the Company.

C. COBRA Continuation Coverage

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

What is COBRA continuation coverage?

In accordance with COBRA law, the employees and eligible Dependents of certain employers may have the opportunity to continue their employer-sponsored healthcare coverage for a limited time, when there is a life event (also known as a qualifying event) that would otherwise result in the loss of coverage under the employer's plan. When a qualifying event causes such loss of coverage, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. The Subscriber, the Subscriber's Spouse and the Subscriber's Dependents are listed under the law as the qualified beneficiaries. COBRA continuation coverage offers the same coverage that the Plan gives to other participants or beneficiaries who are not receiving continuation coverage. The qualified beneficiary may be required to pay the full cost of the continuation coverage for its entire duration.

Do I have other alternatives to COBRA continuation coverage?

COBRA continuation coverage is not the only alternative Members may have when they lose coverage under this 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 tax credit that lowers Your monthly premiums right away, and You can see what Your premium, Deductible Amounts, and Out-of-Pockets Amounts will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special enrollment opportunity for the Marketplace, and You will not be able to enroll until the Marketplace's normal enrollment period opens or Your COBRA continuation coverage is exhausted.

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

Therefore, 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:

a. termination of employment of a covered Employee for reasons other than gross misconduct;

b. loss of eligibility by a covered Employee due to a reduction in the number of work hours of the Employee;

c. death of a covered Subscriber;

d. divorce or legal separation between a covered Subscriber and Spouse;

e. the covered Subscriber becomes entitled to Medicare benefits resulting in the loss of coverage for Dependents;

f. a Dependent child ceases to be an eligible Dependent under the terms of this Benefit Plan; or

g. the Employer files for a Chapter 11 bankruptcy proceeding, but only with respect to covered former Employees who retired from the Employer at any time.

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

Do I have to provide notification of any qualifying event?

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

a. divorce or legal separation;

b. becoming entitled to Medicare; or

c. a Dependent losing eligibility for coverage as a Dependent child.

The Group will advise a qualified beneficiary 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 furnish it to the Group timely. The option to elect continuation coverage will be offered during a period which:

a. begins no later than the date on which a Member otherwise would lose coverage under the Group health plan (the coverage end date); and

b. ends sixty (60) days after the coverage end date or sixty (60) days after the Member is notified of their right to continue coverage, whichever is the latest.

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

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

A Member may be required to pay the entire cost of continuation coverage (including both Employer and Employee contributions) plus an amount to cover administrative expenses. If continuation of coverage is elected, the qualified beneficiary must make 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 forty-five (45) day period, all COBRA continuation coverage rights are lost. Timely monthly payments are required thereafter to keep coverage. Member may not receive notice of payments due.

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

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

a. 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

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

c. the date the Employer ceases to maintain any group health plan for its Employees; or

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

e. 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 became prohibited in 2015 under the Affordable Care Act.); or

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

Can I extend my COBRA continuation coverage?

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

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

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

a. the Employee or former Employee dies;

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

c. the Employee or former Employee and Dependent Spouse divorce;

d. the Dependent child is no longer eligible under the plan as a Dependent.

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

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

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

The 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 Group Informed of Address Changes

To protect Your 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 or Plan Administrator.

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

Employees going on a military leave of absence to perform service in the United States uniformed services (as that term is defined under USERRA) may elect to continue coverage under this Benefit Plan for up to twenty-four (24) months from the date that the Employee leaves for service. Only a covered Employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the Plan immediately before him/her leaving for military service. Dependents do not have any independent right to elect USERRA continuation coverage.

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

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

USERRA continuation coverage may be terminated before the maximum twenty-four (24) month period if:

1. the Employee fails to pay the required premiums timely, or

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

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

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

ARTICLE XXI. COORDINATION OF BENEFITS

A. Applicability

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

2. 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 deductibles, coinsurance or copayments, that are covered in full or in part by any Plan covering the Member. The following are examples of services or expenses that are and are not Allowable Expenses:

   a. A healthcare service or expense or a portion of a service or expense that is not covered by any of the Plans covering a Member is not an allowable expense.

   b. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

   c. If a person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.

   d. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

   e. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   f. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable Expense for all Plans.

   g. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred provider arrangements.

   h. The amount of any expense or portion of an expense for prescription drugs may be an Allowable Expense if authorized by law. A Secondary Plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its plan that is unpaid by the Primary Plan. A Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of any other health care coverage for the prescription drugs and the Secondary Plan may reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed one hundred percent (100%) of the total Allowable Expense.

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 Expense. The COB provisions applies to the part of the Benefit Plan providing healthcare benefits which may be reduced because of the benefits of other Plans. Any other part of the Benefit Plan providing healthcare Benefits is separate from this Benefit Plan. This Benefit Plan may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits.

4. Custodial Parent -

    a. the parent awarded custody of a covered child by a court decree; or

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

5. Order of Benefit Determination Rules – Rules that determine whether this Benefit Plan is a Primary Plan or Secondary Plan when a Member has healthcare coverage under more than one Plan. When this Benefit Plan is Primary, We determine payment for Benefits first before those of any other Plan and without considering any other Plan's benefits. When this Benefit Plan is Secondary, We determine Benefits after those of another Plan and may reduce the Benefits We pay so that all plan benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

6. Plan - Any of the following that provide benefits or services for medical or Dental Care or Treatment. If separate Plans or contracts are used to provide coordinated coverage for members of a group, the separate Plans or contracts are considered parts of the same Plan and there is no COB among those separate Plans or contracts.

    a. Plan includes:

        (1) group and non-group insurance contracts;

        (2) health maintenance organization (HMO) contracts;

        (3) group or group-type coverage through Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured);

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

        (5) the medical benefits in group or individual automobile no fault or traditional automobile or fault contracts;

        (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 in 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 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 regard to 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 subparagraph (f) below, a Plan that does not contain a Coordination of Benefits provision that is consistent with LDI Regulation 32 is always Primary unless the provisions of both Plans state that the complying Plan is Primary.

   f. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits 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 Rules

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

a. Non-Dependent or Dependent Provisions

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 Provisions

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

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(a) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(b) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of subparagraph (3)(b)(1) above shall determine the order of benefits;

(c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of subparagraph (3)(b)(1) above shall determine the order of benefits; or

(d) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent;

(b) The Plan covering the spouse of the Custodial Parent;

(c) The Plan covering the non-Custodial Parent; and then

(d) The Plan covering the spouse of the non-Custodial Parent.

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

(4) For a dependent child covered under the spouse‘s plan:

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

(b) In the event the dependent child’s coverage under the spouse’s plan began on the same date as the dependent child’s coverage under either or both parents’ plans, the order of benefits will be determined by applying the birthday provision above in subparagraph (3)(b)(1) to the child’s parent(s) and the 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 rule 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 and any amounts We would have credited to the Deductible Amount in the absence of other healthcare coverage. In any event, this Benefit Plan will never pay more than We would have paid had We been the Primary Plan.

2. The difference between the Benefit payments that We would have paid had We been the Primary Plan, and the Benefit payments that We actually paid or provided shall be recorded as a benefit reserve for You or a

covered family member and used by Us to pay any Allowable Expenses, not otherwise paid during the plan year. As each Claim is submitted, We will:

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

b. determine whether a benefit reserve has been recorded for You or Your covered family member; and

c. determine whether there are any unpaid Allowable Expenses during the plan year.

3. If there is a benefit reserve, as the Secondary Plan, We will use Your or Your covered family member's Benefit reserve to pay up to one hundred percent (100%) of total Allowable Expenses incurred during the plan year. At the end of the plan year, the benefit reserve returns to zero. A new benefit reserve must be created for each new plan year.

4. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB will not apply between that Plan and other Closed Panel Plans.

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

E. Summary

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

1. Double Coverage

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

2. Primary or Secondary

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

3. When This Benefit Plan is Primary

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

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

b. The Claim is for Your Spouse's healthcare expenses, who is covered by Medicare, and You are not both retired;

c. The Claim is for the healthcare expenses of Your Dependent child who is covered by this Benefit Plan and:

(1) You are married and Your birthday is earlier in the year than Your Spouse's or You are living with another individual, regardless of whether or not You have ever been married to that individual, and Your birthday is earlier than that other individual's birthday. This is known as the birthday rule.

(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 XXII. GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP/POLICYHOLDER AND ALL MEMBERS.

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

A. The Benefit Plan

1. This Benefit Plan, including the Group's acceptance of the Company's proposal, Application, Enrollment Forms, Benefit change forms and renewal forms and documentation, expressing the entire money and other consideration for coverage, the Schedule of Benefits, and any amendments or endorsements, constitutes the entire contract between the parties.

2. Except as specifically provided herein, this Benefit Plan will not make the Company liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Group will be the administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those specifically undertaken by the Company herein. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Member for illness or bodily injury otherwise covered under this Benefit Plan when the illness or bodily injury arises out of an act of domestic violence or a medical condition, including both physical and mental health conditions; or for Emergency Medical Services. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Company harmless in the event the Company incurs any liability as a result of the Group's failure to do so.

3. The Company will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Member's care or treatment.

4. The Company has full discretionary authority to determine eligibility for Benefits and/or to construe the terms of this Benefit Plan. Members that disagree with the Company's determination may pursue any applicable procedures available under the terms of this Benefit Plan and the law.

5. The Company shall have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Company under this Benefit Plan may be performed by the Company or any of its subsidiaries, affiliates, subcontractors, or designees.

B. Section 1557 Grievance Procedure

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

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

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

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

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

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

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

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

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

United States Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-877-696-6775

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

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

C. Benefit Plan Changes

Subject to all applicable laws, We reserve the right to modify the terms of this Benefit Plan in any way permitted. Changes will be preceded by not less than sixty (60) days' notice to the Group and each Subscriber. If required, We will issue to the Group and/or each Subscriber an amendment or endorsement to this Benefit Plan specifying the modification of the terms of this Benefit Plan as well as the effective date of the amendment or endorsement. Changes will be effective upon the effective date denoted in an amendment or endorsement to the Benefit Plan. As permitted by applicable law, notice of changes to the Benefit Plan may be made by mail or electronic means. No change or waiver of any Benefit Plan provision will be effective until approved by Our chief executive officer or a delegate.

D. Benefits to Which Members are Entitled

1. The liability of the Company is limited to the Benefits specified in this Benefit Plan.

2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

3. Continuity of healthcare services.

   a. Upon the termination of a contractual agreement with a Provider, notification of the removal of the Provider from the HMOLA Network will be given by Us to a Member who has begun a course of treatment by the Provider.

   b. A Member who is a continuing care patient has the right to continuity of care until the earlier of the completion of the course of treatment or ninety (90) days after We notify the Member that the Provider has left the HMOLA Network.

   c. A continuing care patient is one who is:

      (1) undergoing a course of treatment for a Serious and Complex Condition;

      (2) undergoing a course of institutional or Inpatient care;

      (3) scheduled to undergo nonelective surgery from the Provider, including receipt of post-operative 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 six (6) months or less, and receiving treatment for the terminal illness from the Provider.

   d. The provisions of continuity of care shall not be applicable if any one of the following occurs:

      (1) The reason for termination of a Provider's contractual agreement is a result of documented reasons relative to quality of care, or the suspension, revocation or applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.

      (2) The reason for termination of a Provider's contractual agreement is the result of fraud.

      (3) The Member voluntarily chooses to change Providers.

      (4) The Member relocates to a location outside of the geographic Service Area of the Provider or the HMOLA Network.

      (5) The Member's condition does not meet the requirements to be deemed a Serious and Complex Condition.

E. Notice of Member Eligibility – Employer's Personnel Data

1. The Group is solely responsible for furnishing the information required for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations, and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate the Company to provide Benefits under this Benefit Plan.

2. All notification of membership or coverage changes must be on forms approved by the Company and include all information required by the Company to effect changes.

3. The Group must notify the Company's membership and billing department using the proper form or notification method, as appropriate, of a Member's termination of coverage. The request for cancellation must be received by the end of the billing cycle immediately following the billing cycle in which the Subscriber is terminated from Group employment or eligibility for coverage ends. For Dependents, the cancellation must be received by the end of the billing cycle immediately following the billing cycle Dependent no longer meets eligibility for coverage. The Group must submit evidence of a Member's election of available continuation of coverage to Our membership and billing department following such termination within three (3) business days of Group's receipt of signed continuation forms from the Member. The Company is under no obligation to refund any premium paid by the Group or any Member, if payment was made to the Company due to Group's failure to timely notify the Company of a Member's termination of coverage.

4. Requests for termination of coverage that are submitted after the period provided above will only be honored prospectively after the date of receipt and the Group will be responsible to pay all corresponding premiums until the effective date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply. Whenever the Group submits a request to the Company to terminate a Subscriber's coverage or that of any of Dependents, the Group will be deemed to be making a representation that neither the Subscriber nor the Subscriber's Dependent has made payments towards the cost of premiums for any coverage period beyond the date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Subscriber or the Subscriber's Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by the Company for such purpose, and to submit any election from the individual for continuation coverage in a separate process.

5. The Group warrants the accuracy of the information it transmits to Us and understands that We will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility if requested by the Company.

6. The Group also agrees to indemnify Us for all expenses We may incur if the Group does not send correct information when required. Indemnification includes, but is not limited to, Claims payments made on behalf of people who are not eligible for Benefits. Alternatively, We may, at Our sole option, hold the Group responsible for all premium payments for Members who are not cancelled from coverage on time because the Group did not notify Us of terminations or changes in eligibility.

F. Termination of Your Coverage

1. The Company may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Benefit Plan. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this coverage. Any information intentionally omitted from the application or enrollment form, as to any proposed Subscriber or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the Effective Date of coverage or terminated within three (3) years of the Member's Effective Date, for fraud or intentional misrepresentation of material fact. The Company will give the Member sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If Members are enrolled that are not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

2. Unless continuation of coverage is available and selected as provided in this Benefit Plan, a Member's coverage terminates as provided below:

   a. The Subscriber's coverage and that of all Dependents terminates automatically and without notice at the end of the billing cycle in which the Subscriber ceases to be eligible.

   b. The coverage of the Subscriber's Spouse will terminate automatically and without notice at the end of the billing cycle for which premiums have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.

   c. The coverage of a Dependent will terminate automatically, and without notice, at the end of the billing cycle in which the Dependent reaches the maximum age for coverage or otherwise ceases to be an eligible Dependent, if premiums have been paid through that period.

   d. Upon the death of a Subscriber, the coverage of all of their surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if premiums have been paid through that period. However, a surviving Spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan or enroll for individual coverage through the Company or the Exchange.

3. In the event the Group cancels this Benefit Plan or the Company terminates this Benefit Plan for nonpayment of the appropriate payment when due or because the Group fails to perform any obligation required by this Benefit Plan, such cancellation or termination alone will operate to end all rights of the Member to Benefits under this Benefit Plan as of the Effective Date of such cancellation or termination. The Group shall have the obligation to notify its Members and beneficiaries of such cancellation or termination. The Company has no such obligation to notify at the Member level.

4. In the event of the occurrence of the provisions of subparagraphs a., b., c. or d. at paragraph 2 above, if the Member is an Inpatient in a Hospital on the date coverage ends, medical Benefits in connection with the Admission for that patient will end at the end of that Admission, or upon reaching any Benefit limitations set in this Benefit Plan, whichever occurs first.

5. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Member for Covered Services rendered after the date of cancellation or termination of a Member's coverage.

6. When Members on the plan change, the Company reserves the right to change the Subscriber's class of coverage and bill appropriate premium to reflect the Members covered.

7. Cancellation or termination will be effective at midnight on the last day of the billing cycle.

8. When the Group's coverage ends because the plan ceases to exist or COBRA is exhausted, Members may apply for individual coverage to the Company or to the Exchange.

G. Filing of Claims

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

2. Most Members with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Member. However, if the Member must file a Claim to access the Prescription Drug Benefit, the Member must use the Prescription Drug Claim form. The Prescription Drug Claim form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Our Pharmacy Benefit Manager, whose number is on Your ID card.

H. Applicable Law and Conforming Policy

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

than the State of Louisiana. This Benefit Plan shall conform to the Essential Health Benefits package and requirements. If any provision of this Benefit Plan is in conflict with any applicable law of the State of Louisiana or the United States of America, the Benefit Plan shall be automatically amended to meet the minimum requirements of the law. Any legal action filed against the plan must be filed in the appropriate court in the State of Louisiana.

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

K. Assignment

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

2. We reserve the right to pay HMOLA Network Providers, and/or Providers in any Blue Cross and Blue Shield of Louisiana Network directly instead of paying the Member.

L. Member/Provider Relationship

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

2. The Company and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or Employees of each other for any purpose whatsoever. The Company does not render Covered Services but only makes payment for Covered Services that the Member receives. The Company will not be held liable for any act or omission of any Provider, or for any Claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the

   Member while receiving care from any Provider or in any Provider's facilities. The Company has no responsibility for a Provider's failure or refusal to render Covered Services to the Member.

3. The use or non-use of an adjective such as 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 having twenty (20) or more active Employees, federal law and regulations require that each active Employee age sixty-five (65) or older, and each active Employee's Spouse age sixty-five (65) or older, may elect to have coverage under this Benefit Plan or under Medicare.

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

b. This Benefit Plan will not provide Benefits to supplement Medicare payments for an active Employee age sixty-five (65) or older or for a Spouse age sixty-five (65) or older of an active Employee where such Employee or such Spouse elects to have the Medicare program as the primary payor.

2. Under federal law, if an active Employee under age sixty-five (65) or an active Employee's Dependent under age sixty-five (65) is covered under a group Benefit Plan of an Employer with one hundred (100) or more Employees and also has coverage under the Medicare program by reason of Social Security disability, this Group Benefit Plan is the primary payor and Medicare is the secondary payor.

3. For persons under age sixty-five (65) who are covered under this Benefit Plan and are eligible for Medicare solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Benefit Plan the secondary payor even if an eligible person has not enrolled in the Medicare program, except that during the first thirty (30) month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, this Benefit Plan will be the primary payor and Medicare the secondary payor.

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

N. Notice

Any notice required to be provided by a Member to Us or a Group to Us under this Benefit Plan must be in writing unless this Benefit Plan specifies other methods of delivery for a particular notice. Notice given to Us will be sent to Our address stated in this Benefit Plan or as specified in this Benefit Plan for other methods of delivery for a particular notice. We may, by written notice, indicate a new address or method of delivery for giving notice.

Notice given to the Group will be sent to the Group's address state in the Application for Group Coverage or, as permitted by La. R.S. 22:2462, by delivery via electronic means to the Group. Any notice required to be given will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Member at their address as the same appears on Our records or by delivery via electronic means to the Member, or the Group at the address as the same appears on Our records or by delivery via electronic means to the Group. The Group or the Member may, by written notice, indicate a new address for receiving notice and the Group or the Member may establish a new email address for receiving notice via electronic means.

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 Subscriber where so required under the provisions of any federal or state laws and/or related programs. This Benefit Plan excludes Benefits for any services rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes. In the event that We initially extend Benefits and a compensation carrier, employer, governmental agency or program, insurer, or any other entity makes any type of settlement with the Member, with any person entitled to receive settlement when the Member dies, or if the Member's injury or illness is found to be compensable under federal or state workers' compensation laws or programs, the Group or the Member must reimburse Us for Benefits extended or direct the compensation carrier, employer, governmental agency, or program, insurer, or any other entity to make such reimbursement. We will be entitled to such reimbursement even if the settlement does not mention or excludes payment for healthcare expenses.

P. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, We will be subrogated and will succeed to the Member's right for the recovery of the amount paid under this Benefit Plan against any person, organization, insurer or other carrier, even where such insurer or carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits under this Benefit Plan

will constitute subrogation. Our right to recover shall be contingent on the Member's right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or a judgment following a trial. We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by the Member in pursuing recovery.

2. The Member will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization, insurer or other carrier, even where such insurer or carrier provides Benefits directly to a Member who is its insured, to the extent of the Benefits provided or paid under this Benefit Plan. Our right to recover will be contingent on the Member's right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or judgment following a trial. We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by the Member in pursuing recovery.

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

4. The Member must notify Us of any Accidental Injury.

Q. Right of Recovery

Whenever any payment for Covered Services has been made by Us in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or whenever payment has been made in error by Us for non-Covered Services, We will have the right to recover such payment from the Member or, if applicable, the Provider. As an alternative, We reserve the right to deduct from any pending Claim for payment under this Benefit Plan any amounts that We are owed by the Member or the Provider.

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

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from 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. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

S. Liability of Plan Affiliates

The Group, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Benefit Plan constitutes a contract solely between Us and the Group, that We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, the Association permitting Us to use the Blue Cross and Blue Shield Service marks in the State of Louisiana, and that We are not contracting as the agent of the Association. The Group, on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Us and that no person, entity, or organization other than Us shall be held accountable or liable to the Group for any of Our obligations to the Group created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this agreement.

T. Out-of-Area Services

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

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

1. BlueCard® Program

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

   The BlueCard® Program enables You to obtain out-of-area Covered Services from a healthcare Provider participating with a Host Blue, where available. The Participating Provider will automatically file a Claim for the out-of-area Covered Services provided to You, so there are no Claim forms for You to fill out. You will be responsible for obtaining any required Authorizations and payment of applicable cost share shown on the Schedule of Benefits.

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

   When You receive Covered Services outside Our Service Area and the Claim is processed through the BlueCard® Program, the amount You pay for Covered Services is calculated based on one of the following, as determined by Us:

   a. the billed charges for Your Covered Services;

   b. the negotiated price that the Host Blue makes available to Us; or

   c. an amount determined by applicable law.

   Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for overestimation or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price We used for Your Claim because We will not apply them after a Claim has already been paid.

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

2. Non-Participating Providers Outside Our Service Area

   a. Member Liability Calculation

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

3. Blue Cross Blue Shield Global® Core

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

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

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

   or call collect:

   1-804-673-1177

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

   a. Inpatient Services

      In most cases, if You contact the Blue Cross Blue Shield Global® Core service center for assistance, and the Provider agrees to accept a guaranteed payment, Hospitals will not require You to pay for covered Inpatient services, except for applicable cost share shown on the Schedule of Benefits. The Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center. However, if the Provider does not agree to a guaranteed payment or You otherwise paid in full at the time of service,

You must submit a Claim to receive reimbursement for Covered Services. You must contact Us to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article and meet other requirements in your Benefit Plan for services to be provided, including, but not limited to, receiving only Medically Necessary services.

b. Outpatient Services

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

c. Exceptions

In situations where the Blue Cross Blue Shield Global® Core service center is unable to obtain a guaranteed payment for a Global® Core claim, We may use other payment methods to figure the payment We will make for the healthcare services that were delivered outside Our Service Area. Those other payment methods include, but are not limited to, 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 from Non-Participating Providers. In these situations, You need to comply with the requirements of your Benefit Plan and You may have to pay the difference between the amount that the Provider bills and the payment We will make for the Covered Services.

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

When You pay for Covered Services outside the BlueCard® service area, You must submit a Claim to obtain reimbursement. For institutional and professional Claims, You should complete a Blue Cross Blue Shield Global® Core Claim form. 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.

Following the instructions on the Claim form will help ensure timely processing of Your Claim. The Claim form is available from Us, the Blue Cross Blue Shield Global® Core service center, or at **www.bcbsglobalcore.com**.

For assistance with Your Claim submission, call:

Blue Cross Blue Shield Global® Core service center
24 hours a day, 7 days a week
1-800-810-BLUE (2583),
or call collect:
1-804-673-1177

U. HIPAA Certificates of Creditable Coverage

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

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 Members whether their Prescription Drug coverage is creditable, which is defined to mean that the coverage is expected to pay on average as much as the standard Medicare Part D Prescription Drug coverage. The types of coverage required to provide the notices are those listed at 42 CFR 423.56(b) and includes, but is not limited to, group health plans (this would mean the Plan Sponsor), individual health insurance coverage, and Medicare supplement plans. For these groups, there are two disclosure requirements:

1. The first disclosure requirement is to provide a written disclosure notice to all Medicare-eligible Members annually who are covered under its Prescription Drug plan, prior to October 15th each year and at various

times as stated in the regulations, including to a Medicare-eligible Member when they join the plan. This disclosure must be provided to Medicare-eligible active working Members and their Dependents, Medicare-eligible COBRA Members and their Dependents, Medicare-eligible disabled Members covered under its Prescription Drug plan and any Retirees and their Dependents. The MMA imposes a late enrollment penalty on Members who do not maintain creditable coverage for a period of sixty-three (63) days or longer following their initial enrollment period for the Medicare Prescription Drug Benefit. Accordingly, this information is essential to a Member's decision whether to enroll in a Medicare Part D Prescription Drug plan.

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

a. prior to the Medicare Part D Annual Coordinated Election Period;

b. prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D (age-in);

c. prior to the Effective Date of coverage for new Medicare-eligible Employees that join this Benefit Plan;

d. whenever Prescription Drug coverage under this Benefit Plan ends or changes so that it is no longer creditable or it becomes creditable; and/or

e. upon a Medicare beneficiary's request.

2. The second disclosure requirement is for groups to complete the Online Disclosure to CMS Form to report the creditable coverage status of their Prescription Drug Plan. The Disclosure should be completed annually no later than sixty (60) days from the beginning of a plan year (contract year, renewal year), within thirty (30) days after termination of a Prescription Drug Plan, or within thirty (30) days after any change in creditable coverage status. This requirement does not pertain to the Medicare beneficiaries for whom groups are receiving the Retiree Drug Subsidy (RDS).

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

W. Continued Coverage During a Leave of Absence

As stated in the Schedule of Eligibility, an Employee must be actively working for the Employer/Group to be entitled to coverage under this Benefit Plan. Each of the following provisions are exceptions to the requirement that the Employee be actively working in order for coverage to apply. The following provisions are independent of each other and only one need apply for the Subscriber and any Dependents to be entitled to continued coverage under this Plan. If Claims are paid when the Employee was not eligible for coverage, the Company may recover the Claims payments.

1. The Company will continue coverage for the Subscriber during any leave of absence the Employer/Group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 (FMLA), the Americans with Disabilities Act or Pregnancy Discrimination Act, and any amendments or successor provisions, as long as all other eligibility criteria under the laws continue to be met. If the Subscriber's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, the Subscriber is entitled to re-enroll for coverage so long as the Employer/Group maintains coverage with the Company. If the Subscriber is not restored to active full-time employment by the end of the leave of absence period, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in the Termination of Your Coverage section. The Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.

2. When a Subscriber has been granted a documented, approved leave of absence by the Employer/Group, and the leave of absence is not due to the Subscriber's health, the Company will maintain coverage for the Subscriber and any covered Dependents for a period not to exceed ninety (90) days. Premiums must be paid and the Subscriber must remain a bona fide Employee of Employer/Group during the approved leave

period. The Employer/Group will provide the Company with proof of the documented leave, upon request. If the Employer/Group terminates the Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in the Termination of Your Coverage section. The Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.

X. Our Right to Offer Premium Incentives

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

1. Encouraging Members and/or policyholders to participate in quality programs;

2. Ensuring Members and/or policyholders are better able to afford benefits packages;

3. Reducing and alleviating social determinants of health;

4. Reducing transition costs for Members and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;

5. Rewarding Members and/or policyholders for choosing lower cost, quality healthcare Providers;

6. Rewarding Members and/or policyholders for selecting lower cost, quality healthcare goods and products;

7. Rewarding Members and/or policyholders for utilizing digital and other paperless forms of communication of information including, but not limited to, plan documents and materials; and

8. Reducing enrollment, technology, or administration costs of Members and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

ARTICLE XXIII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Member is dissatisfied about the care or services the Member receives from HMO Louisiana, Inc. or one of Our Providers. If a Member wants to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

A Member may be dissatisfied about decisions We make regarding Covered Services. We consider a written Appeal as the Member's request to change an Adverse Benefit Determination made by the Company.

Your Appeal rights are outlined below, after the Complaint and Grievance procedures. In addition to the Appeals rights, the Member's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of Our coverage decision when they concern Medical Necessity determinations.

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

A Member is entitled to exhaust applicable appeal rights as described herein. However, submission of claims for or other requests for consideration of coverage for the same benefits that have already been the subject of an appeal and have been decided will be closed without review. Also, multiple requests to Appeal the same Claim, service, issue or date of service will not be considered.

A. Complaint, Grievance, and Informal Reconsideration Procedures

A quality of service concern addresses Our services, access, availability or attitude and those of Network Providers. A quality of care concern addresses the appropriateness of care given to a Member.

1. To Register a Complaint

   A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Members may call customer service to register a Complaint. We will attempt to resolve a Member's Complaint at the time of their call.

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

   Pediatric Dental Care Benefits: call UCD at 1-866-445-5338

   Pediatric Vision Care Benefits: call Davis Vision at 1-888-343-3470

2. To File a Formal Grievance

   A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Member does not feel their Complaint was adequately resolved or the Member wishes to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, the Member may call Our customer service department.

   The Member should send written Grievance to:

   Medical Benefits
   HMO Louisiana, Inc.
   Appeals and Grievance Unit
   P. O. Box 98045
   Baton Rouge, LA 70898-9045

   Pediatric Dental Care Benefits
   HMO Louisiana, Inc.
   c/o United Concordia Dental
   P. O. Box 69420
   Harrisburg, PA 17106-9420

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

3. Informal Reconsideration

An Informal Reconsideration is a request by telephone, made by an Authorized Provider on the Member's behalf, to speak to Our medical director or a peer reviewer about a Utilization Management decision that We have made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

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

B. Standard Appeal Procedures

We offer the Member two (2) levels of Appeal. If a Member is an ERISA Member, the Member is required to complete the first level of Appeal prior to instituting any civil action under ERISA section 502(a). The second level of Appeal is voluntary. Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Member's decision whether or not to submit to this voluntary level of review will have no effect on the Member's rights to any other Benefits under the plan. No fees or costs will be imposed on the Member.

The Member should contact the Employer, Plan Administrator, Plan Sponsor, or Our customer service department at 1-800-599-2583 or 1-225-291-5370 if the Member is unsure whether ERISA is applicable.

The Member may also call Us if they have questions or need assistance putting their Appeal in writing.

C. Standard Appeal Process

We will determine if a Member's Appeal is an administrative Appeal or a medical Appeal. The Appeals procedure has two (2) levels, including review by a committee at the second level on an administrative Appeal and a review by an external Independent Review Organization on a medical Appeal.

The Member is encouraged to provide Us with all available information to help Us completely evaluate the Appeal such as written comments, documents, records, and other information relating to the Adverse Benefit Determination.

We will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination.

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

1. Administrative Appeals

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

Administrative Appeals should be submitted in writing to:

HMO Louisiana, Inc.
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

a. First Level Administrative Appeals

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

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

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

b. Second Level Administrative Appeals

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

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

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

Second level administrative Appeals are not applicable to a Rescission, which follows the External Appeals track.

2. Medical Appeals

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

We offer the Member two (2) standard levels of medical Appeals, including an internal review of the initial Adverse Benefit Determination, then an external review.

Medical Appeals should be submitted in writing to:

HMO Louisiana, Inc.
Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

a. Internal Medical Appeals

If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of Our initial Adverse Benefit Determination for internal medical Appeals. Requests submitted to Us after one hundred eighty (180) days of Our initial Adverse Benefit Determination will not be considered.

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

If the internal medical Appeal is overturned, We will reprocess the Member's Claim, if any. If the internal medical Appeal is upheld, We will inform the Member of their right to begin the External Appeal process if the Adverse Benefit Determination meets the criteria.

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

b. External Medical Appeal and Rescission

For medical Appeals and Rescission, the second level will be handled by an external Independent Review Organization that is not affiliated with Us and randomly assigned by the Louisiana Department of Insurance.

A Member must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization.

If the Member still disagrees with the internal medical Appeal decision or Rescission, a written request for an External Appeal must be submitted within four (4) months of receipt of the internal medical Appeal decision or Rescission.

Requests submitted to Us after four (4) months of receipt of the internal medical Appeal decision or Rescission will not be considered. You are required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the Independent Review Organization. Appeals submitted by your Provider will not be accepted without this form completed with Your signature.

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

The Independent Review Organization decision will be considered a final and binding decision on both the Member and Us for purposes of determining coverage under a health Benefit Plan. This Appeals process shall constitute your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary or Investigational, except to the extent that other remedies are available under State or Federal law.

You may contact the Commissioner of Insurance directly for assistance.

Commissioner of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

D. 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 Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision. An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

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

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

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

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

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

HMO Louisiana, Inc.
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

1. Expedited Internal Medical Appeals

   In these cases, We will make a decision no later than seventy-two (72) hours of Our receipt of an 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 Member or the Provider acting on behalf of the Member, the Appeal may be elevated to an Expedited External Appeal. If an Expedited internal medical Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process and timeframe.

2. Expedited External Medical Appeal

   An Expedited External 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.

For all medical Appeals, the Office of Consumer Advocacy of the Department of Insurance is available to assist with the appeals process. You may contact the Commissioner of Insurance directly for assistance at:

Commissioner of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

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

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

1. Member cost-sharing and surprise billing protections for Emergency Medical Services;

2. Member cost-sharing and surprise billing protections related to care provided by Non-Network Providers at Network facilities;

3. Whether Members are in a condition to receive notice and provide Informed Consent to waive 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 Member cost-sharing and surprise billing; and

5. Continuity of care.

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

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

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

6. NSA Internal Appeals

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

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

HMO Louisiana, Inc.
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

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

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

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

7. NSA External Appeals

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

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

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

HMO Louisiana, Inc.
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

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

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

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

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

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

ARTICLE XXIV. ERISA RIGHTS

To the extent this is an ERISA plan, the Member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For purposes of this provision, the Group is considered the Plan Administrator and will be subject to the provisions stated below. ERISA provides that all plan participants (Members) shall be entitled to:

A. Receive Information About the Plan and Benefits

1. A Member may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Upon written request to the Plan Administrator, a Member may obtain copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. A Member may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

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

C. Prudent Actions by Plan Fiduciaries

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

D. Enforce Member's Rights

1. If a Member's Claim for a plan Benefit is denied or ignored, in whole or in part, the Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps the Member can take to enforce the above rights. A Member must exhaust all Claims and Appeal procedures available before filing any suit. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the Member may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Member up to one hundred ten dollars ($110.00) a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Member has a Claim for Benefits, which is denied or ignored, in whole or in part, the member may file suit in a state or federal court. In addition, if the Member disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such Member may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting rights, the Member may seek assistance from the United States Department of Labor, or the Member may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Member is successful, the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees, for example, if it determines that the Claim is frivolous.

E. Assistance with Member Questions

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

ARTICLE XXV. HOW TO MAKE PLAN CHANGES AND FILE CLAIMS

HMO Louisiana, Inc. is continuing to update its online access for Members. You may now be able to perform many of the functions described below, without contacting Our customer service department. We invite You to log on to **www.lablue.com** for access to these services.

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of Our local service offices*, or from the home office of HMO Louisiana, Inc. If the Member needs to submit documentation to Us, the Member may forward it to Our home office at:

HMO Louisiana, Inc.
P. O. Box 98024
Baton Rouge, LA 70898-9024

or to Our street address,

5525 Reitz Avenue
Baton Rouge, LA 70809.

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

A. Changing Family Members on the Member's Plan

The Schedule of Eligibility lets You know when You may add additional family members to Your plan. Please read the Schedule of Eligibility and this section as they contain important information for You.

You will need to make all plan changes through the agent or through Us. An Employee Enrollment / Change Form is the document that We must receive in order to enroll family members not listed on Your original application/enrollment form. The Employee Enrollment / Change Form is used to add newborn children, newborn adopted children, a Spouse, or other Dependents. It is extremely important that You follow the timing rules in the Schedule of Eligibility. If You do not complete and return a required Employee Enrollment / Change Form to Us within the timeframes set out in the Schedule of Eligibility, it is possible that Your insurance coverage will not be expanded to include the additional family members. Completing and returning an Employee Enrollment / Change Form is especially important when Your first Dependent becomes eligible for coverage or when You no longer have any eligible Dependents.

B. How to File Insurance Claims for Benefits

The Company and most Providers have entered into agreements that eliminate the need for a Member to personally file a Claim for Benefits. Network or Participating Providers will file Claims for Members either by mail or electronically. In certain situations, the Provider may request the Member to file the Claim. If the Member's Provider does request them to file directly with Us, the following information will help the Member in correctly completing the Claim form. If You need to file a paper Claim, send it to:

HMO Louisiana, Inc.
P. O. Box 98024
Baton Rouge, LA 70898-9024

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

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

1. an appropriate Claim form is used;

2. the Member ID number 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 Subscriber is correctly stated;

5. all charges are itemized on a statement from the Provider;

6. the itemized statement from the Provider contains the Provider's name, address and tax ID number and is attached to the Claim form;

7. the date of service (date of Admission to a Hospital or other Provider) or date of treatment is correct;

8. the Provider includes a diagnosis code and a procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form); and

9. the Claim form is completed and signed by the Member and the Provider.

C. Prescription Drug Claims

Most Members with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Members who present an ID card to a Participating Pharmacy. However, if the Member must file a Claim to access their Prescription Drug Benefit, the Member must use the Prescription Drug Claim form. Members may obtain the Prescription Drug Claim form by accessing the pharmacy section of Our website, **www.lablue.com/pharmacy.** The Prescription Drug Claim form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Our Pharmacy Benefit Manager, whose telephone number is on the Member's ID card. Benefits will be paid to the Member based on the Allowable Charge for the Prescription Drug.

D. Other Medical Claims

When the Member receives other medical services (clinics, Provider offices, etc.) the Member should ask if the Provider is a Network or Participating Provider. If yes, this Provider will file the Member's Claim with Us. In some situations, Providers may request payment and ask the Member to file. If this occurs, the Member must be sure the Claim form is complete before forwarding to Us.

If the Member is filing the Claim, the Claim must contain the itemized charges for each procedure or service. 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:

1. full name of patient;
2. date(s) of service;
3. description of and procedure code for service;
4. diagnosis code;
5. charge for service; and
6. name and address of Provider of service.

E. Claims for Nursing Services

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

F. Claims for Durable Medical Equipment (DME)

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

G. Claims for Mental Health and Substance Use Disorders

For help with filing a Claim for the treatment of Mental Health or substance use disorders, the Member should refer to the ID card or call Our customer service department.

H. Claims Questions

Members can view information about the processing or payment of a Claim at **www.lablue.com**. Members 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 Member calls for information about a Claim, We can help the

Member better if they have the information at hand, particularly the Member ID number, patient's name and date of service.

HMO Louisiana, Inc.
P.O. Box 98024
Baton Rouge, LA 70898-9024

Remember, the Member should ALWAYS refer to their Member ID number in all correspondence and recheck it against the Member ID 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 XXVI. GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

IN ADDITION TO THE GENERAL PROVISIONS FOR GROUP/POLICYHOLDER AND MEMBERS ARTICLE, THE FOLLOWING GENERAL PROVISIONS WILL ALSO APPLY TO THE GROUP/POLICYHOLDER.

A. Due Date for Group's Premium Payments

1. Premiums are due and payable from Group/policyholder in advance, prior to coverage being rendered. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. This is the premium due date.

2. Premiums are owed by Group/policyholder. Premiums may not be paid by third-parties including, but not limited to, Hospitals, Pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. The Company will not accept premium payments by third-parties unless required by law to do so. The fact that the Company may have previously accepted a premium from an unrelated third-party does not mean that the Company will accept premiums from these parties in the future.

3. If a premium is not paid when due, the Company may agree to accept a late premium. The Company is not required to accept a late premium. The fact that the Company may have previously accepted a late premium does not mean late premiums will be accepted in the future. You may not rely on the fact that late premiums were previously accepted as indication that the Company will do so in the future.

4. Premiums must be paid in US dollars. The Subscriber will be assessed a twenty-five dollar ($25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, the Company may at its sole discretion refuse to reinstate coverage.

B. Change in Premium Amount

1. Premiums for this Benefit Plan may increase after the Group's first twelve (12) months of coverage and annually thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, We will give the Group forty-five (45) days written notice of any change in premium rates ninety (90) days written notice for Employer groups with more than 100 enrolled Employees). The Company will send notice to the Group's latest address shown in Our records.

   Any increase in premium is effective on the date specified in the rate change notice. Continued payment of premium will constitute acceptance of the change.

2. The Company reserves the right to increase the premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Benefit Plan. This risk includes, but is not limited to, the right to increase the premium amount because of:

   a. the addition of a newly covered person;

   b. the addition of a newly covered entity;

   c. a change in geographic location of any individual insured or policyholder; or

   d. a change in the plan Benefit level from that which was in force at the time of the last rate determination.

   An increase in premium will become effective on the next billing date following the effective date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

C. Group to Distribute and Account for Premium Rebate

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, the Company will pay the Group/Policyholder the total rebate applicable to the plan, and Group, on behalf of the Company, will distribute from the rebate a pro-rata share of the rebate to each Subscriber (including, but not limited to, Employees, retirees, and elected officials as covered on the Group's Benefit Plan) based upon their

contribution to the premium rebated. Group shall assure appropriate notification to federal and state tax agencies and that each payment to Subscribers will be accompanied by appropriate federal and state documentation, e.g., Form 1099. Group shall develop and retain records and documentation evidencing accurate distribution of any rebate and shall provide such records to the Company upon request. Such records shall include:

1. the amount of the premium paid by each Subscriber;

2. the amount of the premium paid by the Group;

3. the amount of the rebate provided to each Subscriber;

4. the amount of the rebate retained by the Group; and

5. the amount of any unclaimed rebate and how and when it will be or was distributed.

Group will assure that any unclaimed rebate amounts will be reported in accordance with the unclaimed property laws of the applicable Subscriber's state of domicile. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this section of the Group Health Benefit Plan.

D. Group's Right to Cancel the Plan

1. This plan is guaranteed issuable and renewable at the option of the Group. Group indicates its desire to continue coverage by its timely payment of each premium as it becomes due.

2. Group may cancel this plan for any reason.

3. To cancel the plan, Group must give the Company WRITTEN NOTICE of its intent to cancel. GROUP MAY NOT VERBALLY CANCEL THIS COVERAGE. GROUP'S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO THE COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE INSURANCE PLAN. If Group's written notice to the Company of its intent to cancel is not accompanied by the surrendered plan, Group's cancellation notice to the Company shall be deemed to include Group's declaration that the Group made a good faith attempt to locate its plan and the plan is not returned because it has been lost or destroyed.

E. The Company's Right to Terminate the Plan for Nonpayment of Premium

1. Premiums are to be prepaid before coverage is rendered. The Group is considered delinquent if premiums are not paid on the due date.

2. The Company offers a thirty (30) day grace period (delinquency period) from the due date of the premium. If premium is not received during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the Benefit Plan. The Company will mail a delinquency/termination notice to the Group's address of record. The Company may automatically terminate the plan without further notice to the Group if premium is not paid to the Company at its home office within thirty (30) days of the due date (during the grace period). Termination will be effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

3. The Group/Policyholder agrees to pay reasonable costs and fees to the Company, including reasonable attorney's fees, for the Company's attempt to collect any amounts owed under this Benefit Plan, including, but not limited to, unpaid premium.

F. The Company's Right to Terminate the Plan for Reasons Other Than Nonpayment of Premium

The Company may terminate this Benefit Plan with sixty (60) days advance written notice to Group, providing the reason for termination, if any one of the following occurs:

1. Group commits fraud or makes an intentional misrepresentation.

2. Group fails to comply with a material plan provision including, but not limited to, provisions relating to eligibility, Employer contributions or group participation rules. If the sole reason for termination is that Group's participation falls to less than one (1) Employee (only the owner is left on the plan), termination of Group coverage will be effective on the Group's next anniversary date. Otherwise, termination for a reason addressed in this paragraph will be effective after Group receives sixty (60) days advance written notice.

3. In the case of Network plans, there is no longer any enrollee under the Group Benefit Plan that lives, resides, or works in the Service Area of the Company or in the area for which the Company is authorized to do business.

4. Group's coverage is provided through a bona fide association and the Employer's membership in the association ends.

5. The Company ceases to offer this product or coverage in the market (ninety (90) days advance written notice will be given to the Group, Members and beneficiaries).

Advance written notice will be given to the Group in accordance with the timeframe required by law.

G. Out-of-Area Services

Please refer to the Out-of-Area Services section in General Provisions – Group / Policyholder and Members Article of this plan for further explanation of these Inter-Plan Arrangements and the BlueCard® Program.

HMO Louisiana, Inc. (HMOLA) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Arrangements. These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross and Blue Shield Association (Association). Whenever Members access healthcare services outside the geographic area HMOLA and Blue Cross and Blue Shield of Louisiana serve, the Claim for those services may be processed through one of these Inter-Plan Arrangements, and the other Blue Cross and/or Blue Shield Licensee (Host Blue) will be responsible contracting and handling all interactions with its Participating Providers. The financial terms of the Blue Cross Blue Shield Global® Core are described generally below.

1. BlueCard® Program Liability Calculation Method Per Claim

   Unless subject to a fixed dollar Copayment, the calculation of the Member liability on Claims for out-of-area Covered Services processed through the BlueCard® Program will be based on the lower of the Provider's billed charges for out-of-area Covered Services or the negotiated price made available to Us by the Host Blue.

   Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to Us by the Host Blue may be represented by one of the following:

   a. An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases, or

   b. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

   c. An average price. An average price is a percentage of billed charges for out-of-area Covered Services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Providers or a similar classification of its Providers and other Claim and non-Claim-

related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether or not it will use an actual price, an estimated price, or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price We pay on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard® Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, HMOLA will include any such surcharge, tax or other fee as part of the Claim charge that will be used to determine any Member liability, and will use them in determining Group's/Policyholder's premium.

2. Non-Participating Providers Outside Our Service Area

   For an explanation on how liability calculations are made for the Claims of Non-Participating Providers outside Our Service Area, please refer to the out-of-area Services section in the General Provisions – Group/Policyholder and Members Article of this plan.

H. United States Economic Sanctions Laws Compliance

The Group hereby agrees to comply fully with all applicable economic sanctions and export control laws and regulations, including those regulations maintained by the United States Treasury Department's Office of Foreign Assets Control (OFAC). The Group understands that HMO Louisiana, Inc. does not authorize extending coverage to any person to whom the provision of such coverage would be receiving insurance coverage under this or other HMO Louisiana, Inc. Policies, including Subscribers and their covered Dependents, against all relevant United States Government lists of persons subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to provide coverage to any person. The Group agrees that its acceptance of coverage constitutes a representation to HMO Louisiana, Inc. that all applicable laws and regulations have been complied with and that coverage is not being provided to any denied person.

Any extension of coverage in breach of the foregoing shall constitute cause for immediate termination of this Benefit Plan, and denial of Benefits for any Claims made under that coverage, and shall entitle HMO Louisiana, Inc. to indemnification from the Group for any cost, loss, damage, liability, or expense incurred by HMO Louisiana, Inc. as a result thereof. This provision shall survive termination or cancellation of this Benefit Plan.

I. Value-Added Programs

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

J. Health Insurance Portability and Accountability Act (Privacy and Security)

1. For purposes of this provision, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

   a. Group Health Plan as defined at 45 CFR Part 160, Sec. 160.103.

   b. Protected Health Information (PHI) as defined at 45 CFR Part 164, Sec. 164.501.

   c. Summary Health Information as defined at 45 CFR Part 164, Sec. 164.504(a).

2. Disclosing Information to the Group

   a. Sharing Summary Health Information with the Group:

      The Company may disclose Summary Health Information to the Group if the Group requests Summary Health Information for purposes of obtaining premium bids from health insurers, HMOs or other third-party payers under the Group Health Plan; or modifying, amending or terminating the Group Health Plan.

   b. Sharing PHI with the Group:

      The Company may disclose PHI to the Group to enable the Group to carry out plan administration functions only upon receipt of a certification from the Group that:

      (1) its plan documents include all of the requirements set forth in 45 CFR Part 164, Sec. 164.504(f)(2)(i), (ii) and (iii);

      (2) it has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520 (B)(1)(iii)(C); and that such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other Benefits or Employee Benefits plan of the Group.

      (3) The Group hereby agrees to abide by the Company's acknowledgement and Authorization policies with regard to the exchange of PHI in an electronic format. For example, if the Company provides data to the Group on a compact disc, the Company may require acknowledgement that the data was received by the Group and the name of the Group representative, which received the data.

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, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@lablue.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries 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 Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.

   Section 1557 Coordinator
   In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
   Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
   Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
   Fax: (225) 298-7240
   Email: Section1557Coordinator@lablue.com

2. If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to **www.lablue.com/checkmyplan**.

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana Inc. and Southern National Life Insurance Company Inc., are independent licensees of the Blue Cross Blue Shield Association.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ພິການຫູ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں. ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583. سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کم‌شنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)