



Group Benefit Plan

For the employees of

Terrebonne General Health System

Administered by



5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802
www.bcbsla.com



**Terrebonne General Health System
COMPREHENSIVE MEDICAL 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 non-network services, in addition to applicable amounts due for copayments, deductible amounts, coinsurances and non-covered services.

Specific information about network and non-network facility-based physicians can be found at www.bcbsla.com or by calling the customer service telephone number on the id card.

Your share of the payment for healthcare services may be based on the agreement between your health plan and your provider. under certain circumstances, this agreement may allow your provider to bill you for amounts up to the provider's regular billed charges.

We base our payment of Benefits for Your Covered Services on an amount know 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 a Plan Participant for non-emergency medical services performed at a Network facility unless the Provider issued the required written notice to a Plan Participant and has obtained a Plan Participant's informed consent to provide such services.

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. 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 the long-term survivorship care. Plan Participants eligible for screenings are those who:

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

These covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with the attending Physician and the Plan Participant. Annual preventive cancer screenings under this Benefit will be subject to any Copayments, Deductible amounts and Coinsurance.

Important information regarding this Plan will be sent to the mailing address provided for a Plan Participant on their Employee Enrollment / Change Form.

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

I. Steven Udvarhelyi, M.D.
President and Chief Executive Officer
Louisiana Health Service & Indemnity Company

**COMPREHENSIVE MEDICAL BENEFIT PLAN
GROUP CARE PPO
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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

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

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

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

Except for necessary technical terms, common words are used to describe the Benefits provided under this Benefit Plan. "We," "Us" and "Our" means BLUE CROSS AND BLUE SHIELD OF LOUISIANA. "You," "Your," and "Yourself" means the Plan Participant and/or enrolled 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.

A. Facts About This Preferred Provider Organization (PPO) Plan

Plan Participants have an extensive Provider Network available to them – Blue Cross and Blue Shield of Louisiana's Preferred Care PPO Network. Plan Participants can also get care from Providers who are not in the Network, but Benefits will be paid at a lower level of Deductible and Coinsurance.

This Benefit Plan is a Preferred Provider Organization (PPO) plan with an Employer Preferred Option (EPO) arrangement for [Medical Group/Facility Name]. As healthcare providers, [Medical Group/Facility Name] offer their employees an Employer Preferred Option Network. Plan Participants who receive care through [Medical Group/Facility Name] will pay the least for their care and get the most value from this Benefit Plan.

Plan Participants also have access to Blue Cross and Blue Shield of Louisiana's Preferred Care PPO Network. Plan Participants can get care from Providers who are not in the Employer Preferred Option Network or Preferred Care PPO Network, but Benefits will be paid at a lower level of Deductible and Coinsurance.

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

Most Benefits are subject to the Plan Participant's payment of a Deductible and Coinsurance or a Copayment as stated in the Schedule of Benefits. The Plan Participant's choice of a Provider determines what you pay. The value of this Plan is maximized when Plan Participants choose care as follows:

Best Value = Employer Preferred Option Network, Imperial Health, LLC.

Better Value = Network Provider

Fair Value = Non-Network Provider

B. Claims Administrator's Provider Network

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

The Preferred Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with the Claims Administrator to participate in the Blue Cross and Blue Shield of Louisiana Preferred Care PPO Provider Network and render services to the Plan Participants. These Providers are called "PPO Providers," "Preferred Providers," or "Network Providers." Oral Surgery Benefits are also available when rendered by Providers in the United Concordia Dental Network (Advantage Plus) or Blue Cross and Blue Shield of Louisiana's dental Network.

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

A Provider's status may change from time to time. Plan Participants should always verify the Network status of a Provider before obtaining services.

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

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

C. Receiving Care Outside the Preferred Network

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

The Plan pays a lower level of Benefits when a Plan Participant uses a Provider outside the Preferred Care PPO Network. Benefits may be based on a lower Allowable Charge. Care obtained outside the Network means the Plan Participant has higher costs and may pay higher Copayments, Deductible amounts and Coinsurance than if care was received in the Network. THESE ADDITIONAL COSTS MAY BE SIGNIFICANT. In addition, the Plan only pays a portion of those charges and it is the Plan Participant's responsibility to pay the remainder. The amount the Plan Participant is required to pay, which could be significant, does not apply to the Out-of-Pocket Amount.

It is recommended that the Plan Participant ask Non-Network Providers to explain their billed charges, before care is received outside the Network. You should review the sample illustration below prior to obtaining care outside the Network.

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

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

In the United States:

Plan Participants receive In-Network Benefits when Emergency and Non-Emergency Covered Services are provided by PPO Providers in other states. If Plan Participants do not go to a PPO Provider, Out-of-Network Benefits will apply. Covered Emergency Services performed in the Emergency Department of a Hospital are paid In-Network.

Outside the United States:

Plan Participants receive In-Network Benefits when covered Emergency and Non-Emergency Services are provided by a Blue Cross Blue Shield Global® Core Provider across the world. If Plan Participants do not go to a Blue Cross Blue Shield Global® Core Provider, Out-of-Network Benefits will apply. Covered Emergency Services performed in the Emergency Department of a Hospital are paid In-Network.

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

E. Authorizations

Some services and supplies require Authorization from the Claims Administrator before services are obtained. Your Schedule of Benefits lists the services, supplies, and Prescription Drugs that require this advance Authorization. See the Care Management Article of this Benefit Plan for additional information regarding Authorization requirements.

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

F. How We Determine What We Pay for the Plan Participant's Covered Services

1. When the Plan Participant uses Network Providers

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

2. When the Plan Participant uses Participating Providers

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

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

3. When the Plan Participant uses Non-Participating Providers

Non-Participating Providers are Providers who have not signed any contract with Blue Cross Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plans. These Providers are not in Our Networks. We have no fee arrangements with them. We 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:

- a. An Amount We establish based on Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;
- b. An Amount We establish as the Allowable Charge; or
- c. The Provider's billed charge. You will receive a lower level of Benefit when they do not go to a Preferred Provider.

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

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

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

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

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

EXAMPLE: A Plan Participant has a PPO plan with a \$500 Deductible Amount. The Plan Participant has 80/20 Coinsurance when he receives Covered Services from Hospitals in the Preferred Network and 60/40 Coinsurance when he receives Covered Services from Hospitals that are not in the Preferred Network Assume the Plan Participant goes to the Hospital, has previously met his Deductible, and has obtained the necessary Authorizations prior to receiving a non-emergency service. The Provider's billed charge for the Covered Services is \$12,000. The Claims Administrator negotiated an Allowable Charge of \$2,500 with its Preferred Network Hospitals to render this service. The Allowable Charge of Participating Providers is \$3,000 to render this service. There is no negotiated rate with the Non-Participating Hospital.

The Plan Participant receives Covered Services from:	Preferred Provider Hospital (Network)	Participating Provider Hospital	Non-Participating Provider Hospital
Provider's Hospital Bill:	\$12,000	\$12,000	\$12,000
Allowable Charge:	\$2,500	\$3,000	\$2,500
The Plan pays:	\$2,000 \$2,500 Allowable Charge x 80% Coinsurance = \$2,000	\$1,800 \$3,000 Allowable Charge x 60% Coinsurance = \$1,800	\$1,500 \$2,500 Allowable Charge x 60% Coinsurance = \$1,500
Plan Participant pays:	\$500 20% Coinsurance x \$2,500 Allowable Charge = \$500	\$1,200 40% Coinsurance x \$3,000 Allowable Charge = \$1,200	\$1,000 \$2,500 Allowable Charge x 40% Coinsurance = \$1,000
Is Plan Participant billed up to the Hospital's billed charge?	NO	NO	YES \$9,500
Total Plan Participant Pays	\$500	\$1,200	\$10,500

H. When a Plan Participant Receives Mental Health or Substance Use Disorder Benefits

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

I. Assignment of Benefits

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

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

J. Plan Participant Incentives and Value-Added Services

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

K. Health Management and Wellness Tools and Resources

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

L. Customer Service E-Mail Address

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

ARTICLE II.

DEFINITIONS

Accidental Injury – A condition which is a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, injuries caused by the act of chewing do not constitute an injury caused by external force. If Benefits are available for the treatment of a particular injury, Benefits will be provided for an injury that results from an act of domestic violence or a medical condition.

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

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

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

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

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

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

Allowable Charge –

- A. For Preferred Providers and Participating Providers - The lesser of the billed charge or the amount established by the Claims Administrator or negotiated as the maximum amount allowed for services from these Providers covered under the terms of this Benefit Plan.
- B. For Non-Participating Providers – The lesser of:
 - 1. An Amount the Claims Administrator establishes based on Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;
 - 2. an Amount the Claims Administrator establishes as the Allowable Charge; or
 - 3. the Provider's billed charge.

Alternative Benefits – Benefits for services not routinely covered under this Benefit Plan but which the Plan may agree to provide when it is beneficial both to the Plan Participant and to the Group.

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

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

Ambulatory Surgical Center – An Allied Health Facility Provider that is established with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight, and which offers the following services whenever a patient is in the center; (1) Anesthesia services as needed for medical operations and procedures performed; (2) Provisions for physical and emotional well-being of patients; (3) Provision for emergency services; (4) Organized administrative structure; and (5) Administrative, statistical and medical records.

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

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

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

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

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

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

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

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

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

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

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

Care Coordination – Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Plan Participant's healthcare needs across the continuum of care.

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

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

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

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

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

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

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

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

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

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

Complaint – An oral expression of dissatisfaction with the Claims Administrator or Provider services.

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

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

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

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

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

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

A. The applicable Copayment, or

B. The Allowable Charge.

In most cases, the Deductible and Coinsurance will be waived for Copayment Services. See the Schedule of Benefits for additional information.

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

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

Deductible Amounts:

A. Individual Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of Allowable charges for Covered Services which a Plan Participant must pay within a Benefit Period before the Plan starts paying Benefits. Once the Family Deductible Amount is satisfied, this Plan starts paying Benefits for

all Plan Participants of the family, regardless whether each has met his Individual Benefit Period Deductible Amount. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits. Network and Non-Network Benefit categories may each carry a separate Individual Deductible Amount as shown in the Schedule of Benefits.

Embedded

- B. Family Deductible Amount – For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Individual Deductible Amount. The Family Deductible Amount is met when the total dollar amount of Allowable Charges for Covered Services, applied to satisfy Individual Benefit Period Deductibles, meets or exceeds the Family Deductible Amount shown in the Schedule of Benefits. This Plan will then start paying Benefits for all Plan Participants within the family, regardless of whether each Plan Participant has met his Individual Deductible. No Plan Participant may contribute more than his Individual Deductible Amount towards satisfying the Family Deductible Amount. Only Individual Deductible Amounts accrue to the Family Deductible Amount. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan. Network and Non-Network Benefit categories may each carry a separate Family Deductible Amount as shown in the Schedule of Benefits.

Embedded, with Multipliers

- C. Family Deductible Amount – For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Individual Deductible Amount. Once the maximum number of Individual Deductibles shown in the Schedule of Benefits has been met; the Family Deductible Amount is satisfied and this Plan starts paying Benefits for all Plan Participants of the family, regardless of whether each Plan Participant has met his Individual Deductible. No Plan Participant may contribute more than his Individual Deductible Amount towards satisfying the Family Deductible Amount. Only Individual Deductible Amounts accrue to the Family Deductible Amount. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan.

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

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

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

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

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

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

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

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

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

Emergency – See "Emergency Medical Condition."

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

Emergency Medical Condition (or "Emergency") – A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the health of the person, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

Emergency Medical Services – 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 Policy;
 - 2. Furnished after the Plan Participant is stabilized; and
 - 3. Part of an Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Medical Services are furnished.

If certain conditions set forth in applicable law are met, the additional services listed above are not deemed to be Emergency Medical Services 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 – Terrebonne General Health System.

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

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

Expedited Appeal – A request for immediate review of an Adverse Benefit Determination involving any of the following situations:

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

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

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

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

Full-Time Equivalent (FTE) – An Employee who: (1) is employed on average 30 or more hours per week; or (2) is working less than 30 hours per week on average, but is in the stability period defined under Internal Revenue Code §54.4980H and regulations issued thereunder. A temporary Employee does not meet the eligibility requirements under this Benefit Plan unless such temporary Employee is determined by the Employer to be an FTE.

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

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 transform of a human embryo to which she makes no generic contribution.

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

Group – Terrebonne General Health System or other legal entity of Terrebonne General Health System who is the Plan Administrator and sponsor of this Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

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

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

HIPAA – The Health Insurance Portability and Accountability Act of 1996 (United States Public Law 104-191) and federal regulations promulgated pursuant thereto.

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

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

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

Imaging Services –

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

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

Independent Review Organization (IRO) – An entity, not affiliated with the Company, 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 Plan Participant and the Company, except to the extent that other remedies are available under state or federal law.

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

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.

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

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

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

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

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

- A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);
 2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. reference to federal regulations.

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

- A. in accordance with nationally accepted standards of medical practice;
- B. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. not primarily for the personal comfort or convenience of the patient, or Provider, and not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies or sequence thereof and that are as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychoses, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by La. R.S. 22:1043 (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under seventeen

(17) years of age; Rett's Disorder; and Tourette's Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic mental disorders, to be determined by the Plan. The definition of Mental Disorder (Mental Health) shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

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

Network Benefits – Benefits for care received from a Network Provider, also referred to as In-Network Benefits.

Network Provider – An Employer Preferred Option Provider or A Provider that has signed an agreement with Us or another Blue Cross and Blue Shield Plan to participate as a member of the Preferred Care Provider Network or another PPO Network. This Provider may also be referred to as a EPO Provider, Preferred Provider or In-Network Provider.

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

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

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

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

Open Enrollment – A period of time, designated by the Plan, during which an eligible Employee and any eligible Dependents may enroll for Benefits under this Plan.

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

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

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

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

Partial Hospitalization Programs – These programs are defined as structured and medically supervised day, evening and/or night treatment programs. Program services are provided to patients at least four (4) hours/day and are available at least three (3) days/week, although some patients may need to attend less often. The services

are of essentially the same nature and intensity (including medical and nursing) as would be provided in a hospital except that the patient is in the program less than twenty-four (24) hours/day. The patient is not considered a resident at the program. The range of services offered is designed to address a Mental Health and/or substance-related disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

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

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

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

Plan – Terrebonne General Health System medical Benefits plan for certain Employees of Terrebonne General Health System, and is described in this document.

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

Plan Participant – Any Employee or Dependent who is covered under this Plan.

Plan Sponsor – Terrebonne General Health System, who provides these Benefits on behalf of its eligible Employees and their eligible Dependents.

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

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

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

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

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 and who is either an Employee Preferred Option Provider or has entered into a contract with the Claims Administrator to participate in its Preferred Network. When performing primary care services, a nurse practitioner and a physician assistant may be treated as a PCP.

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

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, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

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

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

- A. Employer Preferred Option Provider – A Provider of (Terrebonne General Health System. This Provider is also referred to as an EPO Provider or Network Provider.
- B. Preferred Provider Provider(Preferred Care Provider) – A Provider who has entered into a contract with the Claims Administrator to participate in its Preferred Provider, as shown in the Schedule of Benefits. This Provider is also referred to as a Network Provider.
- C. Participating Provider – A Provider that has a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan for other than the Preferred Provider.
- D. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan.

Provider Incentive – An additional amount of compensation paid to a healthcare Provider by a payer, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group or population of covered persons.

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

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

Rehabilitative Care – Healthcare services and devices that help 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, Cardiac Rehabilitation, Pulmonary Rehabilitation and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

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

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

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

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

Retiree/Retired Employee – A former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the amount required from the Retired Employee.

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:
 - 1. Life threatening, degenerative, potentially disabling, or congenital; and
 - 2. Requires specialized medical care over a prolonged period of time.

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

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

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

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Plan) within thirty (30) days of experiencing a HIPPA Special Enrollment Event, including but not limited to, losing other certain health coverage under certain circumstances enumerated by Law (unless a longer period is required by applicable Law) or acquiring a new Dependent as a result of marriage, birth, adoption or placement for adoption.

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

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

- A. Coordination of care is required prior to drug therapy initiation and/or during therapy.
- B. Unique patient compliance and safety monitoring requirements.
- C. Unique requirements for handling, shipping and storage.
- D. 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 Employee's legal Spouse.

Surgery –

- A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic exams, incisional and excisional biopsies and other invasive procedures;
- B. the correction of fractures and dislocations;
- C. Pregnancy Care to include vaginal deliveries and cesarean sections
- D. usual and related pre-operative and post-operative care; or
- E. other procedures as defined and approved by the Plan.

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

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

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

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

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

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

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

Urgent Care Center – A clinic with extended office hours, which provides Urgent Care to patients on an unscheduled basis without need for 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-Based Program (VBP) – An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Waiting Period – See Eligibility Waiting Period.

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

ARTICLE III.

SCHEDULE OF ELIGIBILITY

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

A. Eligibility

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

B. Enrollment for Coverage

1. Every Eligible Person may enroll for coverage under this Plan and may include any Eligible Dependents.
2. The Plan Administrator will submit all enrollment information to the Claims Administrator as a prerequisite to coverage under this Plan.

C. Available Classes of Coverage

The classes of coverage defined below are available subject to the selection of class or classes of coverage by the Plan as shown on the Application for Group Coverage. The Plan has the right to change the classes of

coverage selected when needed by sending a request to change classes to Claim Administrator's Underwriting Department.

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

D. Effective Date

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

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

E. Court Ordered Determination

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

F. Special Enrollment

1. Special Enrollment Due to Loss of Certain Other Coverage

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

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

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

- a. the Eligible Person must be eligible for coverage under the terms of this Plan;
- b. the Eligible Person must have declined enrollment under this Plan when offered;
- c. the Eligible Person lost coverage under a plan considered Creditable Coverage for HIPAA Portability purposes;
- d. the Eligible Person coverage described in c. above:
 - (1) was under a COBRA continuation provision and the COBRA continuation period was exhausted due to one of the following:
 - (a) The full COBRA continuation period was exhausted;
 - (b) the Employer or other responsible entity failed to remit required premiums on a timely basis;
 - (c) the individual whose coverage is through a Health Maintenance Organization (HMO), no longer lives, resides or works in the service area the HMO services, whether or not the choice of the individual in the service area, and there is no other COBRA coverage available;
 - (2) was not under a COBRA continuation provision and lost other health coverage due to:
 - (a) loss of eligibility for coverage. Loss of eligibility for coverage includes but is not limited to the following:
 - (i) loss of eligibility as a result of legal separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the hours of employment;
 - (ii) in the case of coverage offered through a Health Maintenance Organization (HMO) in the individual market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual;
 - (iii) in the case of coverage offered through an HMO in the group market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual, and no other health coverage is available to the individual;
 - (iv) a plan no longer offers any Benefits to the class of similarly situated individuals.
 - (b) termination of employer contributions to the other coverage.

A Special Enrollee under this section must request enrollment for coverage under this Plan within thirty (30) days after other coverage ends (or after the Employer stops contributing toward the other non-COBRA coverage). Coverage will become effective on the date other coverage is lost. Coverage will not be available if the Plan does not receive the signed enrollment form within thirty (30) days of the loss of other coverage.

- 2. Special Enrollment of a Dependent Child Due to Loss of Coverage under the Children's Health Insurance Program or a Medicaid Program
 - a. This Benefit Plan provides a Special Enrollment Period for an Employee or family Dependent(s) if either (1) covered under Medicaid or State Children's Health Insurance Program ("CHIP"), and loses that coverage because of loss of eligibility; or (2) becomes eligible for premium assistance under the CHIP program. To qualify, the Employee must request coverage in this group health plan no later than sixty (60) days after either the date of coverage termination under Medicaid or CHIP or the date the Employee or Dependent is determined to be eligible for such premium assistance.

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

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

3. Special Enrollment Due to Acquiring a Dependent

- a. This Plan shall provide for a special enrollment period during which the Dependent of a participating Employee may be enrolled on the Plan. If not already participating, a current Employee may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period.
 - b. A person becomes a Dependent of the covered or eligible Employee through marriage, birth, adoption, or placement for adoption. In the case of the birth, adoption, or placement for adoption of a child, the Spouse of the Employee may be enrolled as a Dependent if he is otherwise eligible for coverage.
 - c. If the Plan Administrator offers multiple health plan options, another option may be chosen by the current Employee for himself and Dependents when special enrollee status applies.
 - d. The Special Enrollment Period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied
 - e. In the case of a birth, adoption, or placement for adoption, a current Employee may enroll himself, his Spouse and/or the newborn/adopted child and other eligible dependent children. The enrollment must be requested by signing an enrollment form within thirty (30) days after the birth, adoption, or placement for adoption. Coverage will become effective on the date of birth, adoption, or placement for adoption. An Employee may enroll an unborn child prior to birth; however, coverage will not be effective until the date of birth. Coverage will not be available if the Plan does not receive the signed enrollment form within thirty (30) days of birth, adoption or placement for adoption.
 - f. In the case of marriage, a current Employee may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested by signing an enrollment form within thirty (30) days of the marriage. Coverage will become effective on the date of marriage. Coverage will not be available if the Plan does not receive the signed enrollment form within thirty (30) days of marriage.
4. In all Special Enrollee circumstances, an Employee must be enrolled in this Plan in order for his Dependent(s) to be enrolled.

ARTICLE IV.

BENEFITS

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

A. Benefit Categories

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

Network and Non-Network Benefit categories may each carry separate Deductibles and Out-of-Pocket Amounts, as shown in the Schedule of Benefits.

B. Deductibles and Coinsurance

1. Subject to the Deductible Amounts shown in the Schedule of Benefits, the maximum limitations hereinafter provided, and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in accordance with the Coinsurance percentage shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period. The following deductibles may apply to Benefits provided by this Plan. Deductibles will accrue to the Out-of-Pocket Amount.
 - a. Individual Deductible Amount: The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that the Plan Participant must pay within a Benefit Period before the Plan starts paying Benefits. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits.

Embedded

Family Deductible Amount – For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Individual Deductible Amount. The Family Deductible Amount is met when the total dollar amount of Allowable Charges for Covered Services, applied to satisfy Individual Benefit Period Deductibles, meets or exceeds the Family Deductible Amount shown in the Schedule of Benefits. This Plan will then start paying Benefits for all Plan Participants within the family, regardless of whether each Plan Participant has met his Individual Deductible. No Plan Participant may contribute more than his Individual Deductible Amount towards satisfying the Family Deductible Amount. Only Individual Deductible Amounts accrue to the Family Deductible Amount. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan. Network and Non-Network Benefit categories may each carry a separate Family Deductible Amount as shown in the Schedule of Benefits.

Embedded, with Multipliers

Family Deductible Amount – For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Individual Deductible Amount. Once the maximum number of Individual Deductibles shown in the Schedule of Benefits has been met; the Family Deductible Amount is satisfied and this Plan starts paying Benefits for all Plan Participants of the family, regardless of whether each Plan Participant has met his Individual Deductible. No Plan Participant may contribute more than his Individual Deductible Amount towards satisfying the Family Deductible Amount. Only Individual Deductible Amounts accrue to the Family Deductible Amount. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan.

2. The Coinsurance percentage is shown on the Schedule of Benefits for a Covered Service. The Plan Participant must first pay any applicable Deductible Amount before the Coinsurance percentage. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in the Coinsurance shown in the Schedule of Benefits toward Allowable Charges for Covered Services. The actual payment to a Provider or payment to the Plan Participant satisfies the Plan Sponsor's obligation to provide Benefits under this Benefit Plan.
3. This Benefit Plan does not provide a fourth-quarter Deductible carryover for charges incurred for Covered Services incurred during the months of October, November and December.
4. The Claims Administrator will apply the Plan Participant's Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by the Claims Administrator. The Claims Administrator's system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays his Deductible Amount, he is entitled to receive a refund from the Provider to whom the overpayment was made.
5. Under certain circumstances, if the Plan pays a healthcare Provider amounts that are the Plan Participant's responsibility such as Copayments, Deductible amounts and Coinsurance the Plan may collect such amounts directly from You.

C. Out-of-Pocket Amount

1. After the Plan Participant has met the applicable Out-of-Pocket Amount, as shown in the Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Allowable Charges for Covered Services for all covered family members for the remainder of the Benefit Period.
2. The following accrue to the Out-of-Pocket Amount of this Benefit Plan:
 - a. Coinsurance;
 - b. Deductible Amounts;
 - c. Copayment Amounts; and
 - d. Prescription Drug Deductible Amounts.
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 Plan Participant or Provider must pay;
 - c. charges for non-Covered Services; and
 - d. any other amounts paid by the Plan Participant other than Copayments, Deductible amounts and Coinsurance.

ARTICLE II. 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 outlined in the Care Management Article of this Benefit Plan. In addition, at regular intervals during the Inpatient stay, the Claims Administrator will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care. The Plan Participant must pay any applicable Copayment, Deductible amounts and Coinsurance shown in the Schedule of Benefits. The following services furnished to a Plan Participant by a Hospital are covered.

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Plan Participant requiring an intensive level of care.
3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us. Coverage limitations are shown in the Schedule of Benefits.
4. In a Residential Treatment Center for Plan Participants with a Mental disorder or substance use disorder.

B. Other Hospital Services (Inpatient and Outpatient)

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

C. Pre-Admission Testing Benefits

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

ARTICLE III.

MEDICAL AND SURGICAL BENEFITS

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

A. Surgical Services

1. Surgery

- a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by the Plan and is that period of time which is appropriate as routine care for the particular surgical procedure.
- b. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

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

a. Primary Service

- (1) The primary or major service will be determined by the Claims Administrator.
- (2) Benefits for the primary service will be based on the Allowable Charge.

b. Secondary Service

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

c. Incidental Service

- (1) An incidental service is one carried out at the same time as a primary service as determined by the Claims Administrator.
- (2) Covered incidental service(s) are not reimbursed separately. The Allowable Charge for the primary service includes coverage for any incidental services. If the primary service is not covered, any incidental services 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 procedure code as determined by the Claims Administrator.
- (2) The Allowable Charge of the comprehensive service code includes the charge for the unbundled services. The Plan will provide Benefits according to the proper comprehensive service code, as determined by the Claims Administrator.

e. Mutually Exclusive Services

- (1) Mutually exclusive services are two (2) or more services that usually are not performed at the same operative session or encounter on the same patient, on the same date of service, and for which separate billings are made. Mutually exclusive services may also include different service code descriptions for the same type of services in which the Physician should be submitting only one (1) of the codes. One 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 by the Plan and approved by the Claims Administrator. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.
- b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless the Claims Administrator determines otherwise.
- c. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

5. Second Surgical Opinion

Benefits will be provided for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. Second or third opinion consultant must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory in order to receive Benefits.

B. Inpatient Medical Services

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

1. Inpatient medical care visits;
2. Concurrent Care; and
3. Consultation (as defined in this Benefit Plan).

C. Outpatient Medical and Surgical Services

1. Home, office, and other Outpatient visits for examination, diagnosis, and treatment of an illness or injury. Benefits for Outpatient medical services do not include separate payments for routine pre-operative and post-operative medical visits for Surgery or Pregnancy Care.
2. Consultation (as defined in this Benefit Plan);
3. Diagnostic Services;
4. services of an Ambulatory Surgical Center; and
5. services of an Urgent Care Center.

D. Expanded Medical and Surgical Benefits

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

ARTICLE IV. PREVENTIVE OR WELLNESS CARE

Preventive and Wellness Care services are covered unless otherwise noted in the service description. New services are also covered when required by law.

This Benefit Plan covers 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. The list of Covered Services changes from time to time. New Preventive or Wellness Care services usually become covered within one year from the date recommended. To check the current list of recommended services, visit the United States Department of Health and Human Services' website at: <https://www.healthcare.gov/preventive-care-benefits/> or contact Our customer service department at the telephone number on Your ID card.

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

A. Preventive or Wellness Care Benefits.

1. Network Benefits – Covered in full, no Copayments, Deductible amounts and Coinsurance applied.
2. Non-Network Benefits – Covered subject to any applicable Deductible and Coinsurance amounts shown in the Schedule of Benefits.

B. COVID-19 Services

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

applicable Copayments, Deductible amounts and Coinsurance, as shown on the Schedule of Benefits for Network or Non-Network Providers.

Limitation on Approved Over-the-Counter (OTC) Tests for Covid-19

There is no coverage under this medical benefit plan for OTC Covid-19 tests. Please contact Your Plan or Your Plan’s Pharmacy Benefit Manager for information on coverage for OTC Covid-19 tests.

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

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

C. The following Preventive or Wellness Care services are available to a Plan Participant.

PREVENTIVE OR WELLNESS CARE SERVICES	AGE / CRITERIA
EXAMINATIONS AND TESTING – ALL ADULTS	
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels). Limited to one (1) per Benefit Period. High-Tech Imaging services such as an MRI, MRA, CT Scan, PET Scan, and nuclear cardiology are not covered under this Preventive or Wellness Benefit but may be covered under standard Benefits.	All Ages
Colorectal Cancer Screening – <ul style="list-style-type: none"> • Fecal immunochemical test (FIT) for Blood : One (1) per Benefit Period • Flexible sigmoidoscopy: One (1) every five (5) years • Colonoscopy: One (1) every ten (10) years • Physician prescribed colonoscopy preparation medications: Limit of two (2) prescriptions for selected generic drugs. • Cologuard DNA Testing: One (1) per Benefit Period • Computed Tomographic (CT) Colonography: One (1) every five (5) years Any additional screenings will be subject to Deductible Amounts and Coinsurance shown in the Schedule of Benefits. Services deemed Investigational are not covered	Ages 45 – 75
IMMUNIZATIONS – ALL ADULTS	
Immunizations recommended by Physician	All Ages
Seasonal Flu and H1N1 Immunizations	All Ages

SCREENINGS, COUNSELING AND SUPPLEMENTS – ALL ADULTS	
Aspirin Counseling for Prevention of Cardiovascular Disease and Colorectal Cancer	Men: Ages 50 – 59 Women: Ages 50 – 59
Blood Pressure Screening <ul style="list-style-type: none"> Office Blood Pressure Monitoring Ambulatory Blood Pressure Monitoring (ABPM) Home Blood Pressure Monitoring (HBPM) One (1) per Benefit Period for services listed above. <ul style="list-style-type: none"> Annual Blood Pressure Screening 	Ages 18 and older. 40 years or older and those at increased risk for high blood pressure.
Cardiovascular Disease Counseling	Adults with cardiovascular disease risk factors
Cholesterol Screening	Men: Ages 20 – 35 if at risk; or 35 and older Women: Ages 20 – 45 if at risk; or 45 and older
Depression and Suicide Risk Screening	All Ages
Diet Counseling	Adults with hyperlipidemia and other risk factors
Fall Prevention Intervention	Ages 65 and older
Generic low-to-moderate dose statins	40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
Generic/Single Source Brand Prescription and Over-the-Counter Smoking Cessation Products: Limit 180 days per calendar year	Ages 18 and older
Hepatitis B Screening	High risk adults
Hepatitis C Screening	Adults: Ages 18 – 79 years
HIV Screening and Counseling	Ages 15 – 65; younger or older if at increased risk
Lung Cancer Counseling	All Ages
Lung Cancer Screening	Ages 50 – 80 (per guidelines for smoking history)
Obesity Screening and Counseling: Twenty-Four (24) per Benefit Period. Must use Network Provider to obtain Benefit.	Adults with a body mass index higher than 30 kg/m ²

Preexposure Prophylaxis (PrEP) for HIV Prevention	Persons at high risk of HIV acquisition
Sexually Transmitted Infections Counseling	Sexually active adults at increased risk
Skin Cancer Screening	Ages 6 months – 24 years
Syphilis Screening	Adults at increased risk
Tobacco Use Screening and Counseling	All ages
Latent Tuberculosis infection (LTBI) screening	Asymptomatic adults 18 years and older at increased risk for infection
Prediabetes and Type 2 Diabetes Screening	Persons who are overweight or obese
Unhealthy Alcohol Use Screening and Counseling	Adults: Ages 18 and older
Unhealthy Drug Use Screening	Adults: Ages 18 and older
COVERED SERVICES FOR FEMALES	
Contraceptives – All Food and Drug Administration approved, granted or cleared methods, as prescribed by a Physician	Women with reproductive capacity
Anxiety/Behavioral*Social/Emotional Screening	Women and adolescent females
BRCA 1 & BRCA 2 Genetic Testing – Screening and Counseling	Women with family history of risk (per guidelines)
Breast Cancer Chemoprevention Counseling	Women at risk for breast cancer
Chlamydia Infection Screening	Women, including pregnant persons, ages 24 and younger who are sexually active; older if at increased risk
Generic Folic Acid Supplements (Prescription Drug Benefit) – 0.4mg to 0.8mg/day	Women who are planning or capable of pregnancy: Ages 15 – 44
Gonorrhea Screening	Women, including pregnant persons, ages 24 and younger who are sexually active; older if at increased risk
Human Papillomavirus (HPV) DNA testing – Limit of one (1) every five (5) years. Testing may be completed alone or in conjunction with a routine pap smear.	Ages 30 – 65 years

Intimate Partner Violence Screening and Counseling	Ages 14 – 50
<p>Mammography Examination, including Breast Ultrasound</p> <ul style="list-style-type: none"> • Annual Mammogram for women with hereditary susceptibility or prior chest wall radiation • One baseline Mammogram • Annual Mammogram and access to supplemental imaging (Breast MRI) upon recommendation of Physician for women with >20% predicted lifetime risk • Annual Mammogram and Supplemental Imaging (breast ultrasound, then Breast MRI if breast ultrasound is inconclusive) if recommended by Physician for women with C and D breast density <p>A breast ultrasound may be completed alone or in conjunction with a mammogram. See below for details on coverage of Breast MRIs.</p>	<p>Age 30+</p> <p>Ages 35 – 39</p> <p>Age 35+</p> <p>Age 40+</p>
<p>Breast MRIs</p> <ul style="list-style-type: none"> • Annual Breast MRI for women with hereditary susceptibility or prior chest wall radiation • Access to supplemental imaging (Breast MRI) upon recommendation of physician for women with >20% predicted lifetime risk • Supplemental imaging (Breast MRI if breast ultrasound is inconclusive if recommended by Physician for women with C and D breast density • Annual Breast MRI if recommended by Physician for women with prior history of breast cancer under 50 years of age • Annual Breast MRI if recommended by Physician for women with prior history of breast cancer at any age with C and D breast density <p>Benefits will not be paid at one hundred percent (100%). The Deductible Amount, if applicable, will be waived. All other MRIs payable same as High-Tech Imaging Services. Prior Authorization may be required if shown in the Schedule of Benefits.</p>	<p>Age 25+</p> <p>Age 35+</p> <p>Age 40+</p>
Medications for Risk Reduction of Primary Breast Cancer	Asymptomatic Women: Ages 35 years or older without a prior diagnosis of breast cancer and who are at increased risk for breast cancer
Obesity Prevention Counseling	Midlife women ages 40 to 60 years with normal or overweight body mass index (BMI) (18.5–29.9 kg/m ²)
<p>Osteoporosis Screening:</p> <ul style="list-style-type: none"> • One (1) per Benefit Period • One (1) every two (2) years 	<p>Ages 65 or older</p> <p>Younger postmenopausal women at risk (per guidelines)</p>

Permanent Sterilization Method	Women with reproductive capacity
Routine Gynecologist or Obstetrician Visits	As age and developmentally appropriate
Routine Pap Smear – One (1) per Benefit Period	All Ages
Sexually Transmitted Infections Counseling	Sexually active women
Urinary Incontinence Screening – Annually	Impacts activities of life of women
Violence and Domestic Abuse Counseling – Annually	Women and adolescent females
COVERED SERVICES FOR PREGNANT FEMALES	
Aspirin – 81mg for prevention of preeclampsia, generic over-the-counter, (Prescription Drug Benefit)	Ages 54 or younger after 12 weeks of gestation
Anemia Screening	During pregnancy
Anxiety/Behavioral/Social/Emotional Screening	During pregnancy or the postpartum period
Bacteriuria Screening	During 12 – 16 weeks of gestation or at first prenatal visit
Breast Feeding Intervention	During pregnancy and after birth
Counseling for Healthy Weight & Weight Gain in Pregnancy	During Pregnancy
Diabetes After Pregnancy Screening Initial testing should ideally occur within the first year postpartum.	During the postpartum period for women with a history of gestational diabetes who are not currently pregnant and have not been previously diagnosed with type 2 diabetes
Electric and Manual Breast Pumps	During the postpartum period
Gestational Diabetes Testing and Screening	Asymptomatic pregnant women after 24 weeks of gestation
Hepatitis B Screening	During first prenatal visit
Lactation Counseling	During pregnancy and after each birth

Lactation Supplies for Machine Use Only Limit of eight (8) boxes for milk storage bags per Benefit Period.	During the postpartum period
Perinatal Depression Prevention: eighteen (18) counseling visits per Benefit Period	During pregnancy and up to 1 (one) year postpartum for women who do not have a current diagnosis of depression but are at increased risk
Preeclampsia Screening	Throughout the pregnancy
Rh Incompatibility Screening	Pregnant women during 24 – 28 weeks of gestation if at risk or at first prenatal visit
Syphilis Screening	During pregnancy
Tobacco Use Screening and Interventions, with Expanded Counseling	During pregnancy
COVERED SERVICES FOR MALES	
Abdominal Aortic Aneurysm Screening: One-time (1) Screening	Men who have smoked: Ages 65 – 75
Prostate Cancer Screening <ul style="list-style-type: none"> Routine digital rectal exam: One (1) per Benefit Period Prostate Specific Antigen (PSA) test: One (1) per Benefit Period Second visit: For follow-up treatment within 60 days after the visit if it is related to a condition that is diagnosed or treated during the visit and recommended by a doctor 	Ages 50 and older or as recommended by doctor for ages 40 – 49 Ages 50 and older or as recommended by a doctor for ages 40 – 69 Older than 40 years
COVERED SERVICES FOR CHILDREN & ADOLESCENTS	
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels). Limited to one (1) per Benefit Period. High-Tech Imaging services such as an MRI, MRA, CT Scan, PET Scan and nuclear cardiology are not covered under this Preventive or Wellness Benefit but may be covered under standard Benefits.	All Ages
Well baby care	As recommended by Physician for developmental milestones
Immunizations recommended by Physician	All Ages
Seasonal Flu and H1N1 Immunizations	All Ages
Alcohol and Drug Use Assessments	Ages 11 – 21

Anxiety/Behavioral/Social/Emotional Screening	Ages 0-21
Autism Screening	Ages 1 – 2
Behavioral Assessments	Ages 0 – 21
Blood Pressure Screening	Ages 0 - 17
Cervical Dysplasia Screening	Adolescent Girls: Ages 11 - 21
Chlamydia Infection Screening	Ages 24, including pregnant persons, and younger who are sexually active
Congenital Hypothyroidism Screening	Newborns
Depression and Suicide Risk Screening	Ages 12 – 18
Developmental Screening	Varied Intervals: Ages 0 – 3
Dyslipidemia Screening	Varied intervals beginning at 24 months
Fluoride Chemoprevention Supplements	Ages 6 months – 16 years
Gonorrhea Prophylactic Ocular Medication	Newborns
Gonorrhea Screening	Ages 24 and younger, including pregnant persons, who are sexually active
Hearing Screening: One (1) per Benefit Period.	Ages 0 – 21
Height, Weight and Body Mass Index Measurements	Ages 2 – 21
Hematocrit or Hemoglobin Screening	Varied intervals: Ages 4 months – 21 years
Hepatitis B Screening	High risk adolescents
HIV Screening and Counseling	Adolescents
Intimate Partner Violence Screening and Counseling	Ages 14 - 50
Lead Screening: One (1) per Benefit Period	Ages 0 – 6
Obesity Screening and Counseling	Ages 3 - 18
Oral Health Assessment	Varied intervals between 6 months – 6 years
Phenylketonuria (PKU)	Newborns

Preexposure Prophylaxis (PrEP) for HIV Prevention	Persons at high risk of HIV acquisition
Sexually Transmitted Infections Counseling	Sexually active adolescents
Sickle Cell Screening	Newborns
Skin Cancer Counseling	Ages 6 Months – 24 years
Syphilis Screening	Adolescents at increased risk
Tobacco Use Screening and Counseling	School-aged children and adolescents
Tuberculosis Screening: One (1) per Benefit Period	Ages 0 – 21
Violence and domestic abuse counseling	As needed
Vision Screening: One (1) per Benefit Period	Ages 0 – 21

ARTICLE V. MENTAL HEALTH BENEFITS

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

ARTICLE VI. SUBSTANCE USE DISORDER BENEFITS

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

ARTICLE VII. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, Providers in the Preferred Network, the United Concordia Dental Network (Advantage Plus) or Blue Cross and Blue Shield of Louisiana’s dental Network are considered Network Providers. Plan Participants may access these Networks online at www.bcbsla.com, or by calling the customer service telephone number on their ID cards. Coverage is provided only for the following services or procedures.

- A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- B. Extraction of impacted teeth.
- C. Dental Care and Treatment, including Surgery and dental appliances, required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.)

- D. Excision of exostoses or tori of the jaws and hard palate.
- E. Incision and drainage of abscess and treatment of cellulitis.
- F. Incision of accessory sinuses, salivary glands, and salivary ducts.
- G. Anesthesia for the above services or procedures when rendered by an oral surgeon.
- H. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Plan Participant's mental or physical condition requires dental treatment to be rendered in a Hospital setting.
- J. Benefits are available for dental services not otherwise covered by this Plan, when specifically required to restore bodily function for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To obtain more information how to access these medical Benefits, please call the Claims Administrator's customer service department at the phone number on the Plan Participant's ID card, and ask to speak to a Case Manager.
- K. Diagnosis, therapeutic, or surgical procedures related to Temporomandibular Joint Syndrome and associated musculature and neurological conditions. Services may require prior Authorization, as shown on Your Schedule of Benefits.

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

OUR AUTHORIZATION IS REQUIRED FOR THE EVALUATION OF A PLAN PARTICIPANT'S SUITABILITY FOR ALL SOLID ORGAN AND BONE MARROW TRANSPLANTS AND PROCEDURES. FOR THE PURPOSES OF COVERAGE UNDER THE PLAN, ALL AUTOLOGOUS PROCEDURES ARE CONSIDERED TRANSPLANTS.

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

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) or a Blue Cross and Blue Shield of Louisiana (BCBSLA) Preferred Provider facility, unless otherwise approved by the Claims Administrator in writing. To locate an approved facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their ID card.
2. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

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

a. Solid Human Organ Transplants of the:

- (1) liver;
- (2) heart;
- (3) lung;
- (4) kidney;
- (5) pancreas;
- (6) small bowel; and
- (7) other solid organ transplant procedures which the Claims Administrator determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.

b. Tissue Transplant Procedures (Autologous and Allogeneic)

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

The following tissue transplants are covered:

- (1) blood transfusions;
- (2) autologous parathyroid transplants;
- (3) corneal transplants;
- (4) bone and cartilage grafting;
- (5) skin grafting;
- (6) autologous islet cell transplants; and
- (7) other tissue transplant procedures which the Claims Administrator determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case-by-case basis.

c. Bone Marrow Transplants

- (1) Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.
- (2) Other bone marrow transplant procedures which the Claims Administrator determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These bone marrow transplant procedures will be considered on a case-by-case basis.

ARTICLE IX. PREGNANCY CARE AND NEWBORN CARE BENEFITS

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

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

The Claims Administrator has several maternity programs available to help pregnant Plan Participants deliver healthy babies. Please call Our customer service department, at the number on the back of Your ID card, when You learn You are having a baby. We will advise about the programs available to You.

A. Pregnancy Care

1. Medical and Surgical Services

- a. Initial office visit and visits during the term of the pregnancy
- b. Diagnostic Services
- c. Delivery, including necessary pre-natal and post-natal care
- d. Medically Necessary abortions required in order to save the life of the mother

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

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

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

1. Medical and Surgical services rendered by a Physician, for treatment of illness, pre-maturity, post-maturity, congenital condition and for circumcision of a newborn are covered. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.
2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, pre-maturity, post-maturity, and congenital condition of a newborn are covered. Charges for services for a well newborn, including the Hospital (nursery) charge should not be billed separately from the mother's Hospital bill. As determined by Us well newborn charges may be covered if the Plan Participant under this Plan is the father.

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

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

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

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

ARTICLE X. REHABILITATIVE AND HABILITATIVE CARE BENEFITS

Rehabilitative and Habilitative Care Benefits will be available for the following services and devices provided on an Inpatient or Outpatient basis.

- Occupational Therapy
- Physical Therapy
- Speech/Language Pathology Therapy
- Chiropractic Services
- Cardiac Rehabilitation
- Pulmonary Rehabilitation

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

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

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

Benefits under this Article are in addition to, but not a duplication of, the Benefits provided under any other provision of this Benefit Plan. Any Benefits provided under any other provision of this Benefit Plan will not be eligible Benefits under this Article.

A. Occupational Therapy

1. Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his license, including, but not limited to a licensed occupational therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.
2. Occupational Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.
3. Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.

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

B. Physical Therapy

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license.
2. Physical Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.
3. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.
4. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances, if listed as a Covered Service:
 - a. to children with a diagnosed developmental disability pursuant to the Plan Participant's plan of care;
 - b. as part of a Home Health Care agency pursuant to the Plan Participant's plan of care;
 - c. to a patient in a nursing home pursuant to the Plan Participant's plan of care;
 - d. related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness; or
 - e. to an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered when performed by a Provider licensed to practice in the state in which the services are rendered and practicing within the scope of his license, including, but not limited to, a speech pathologist or by an audiologist.
2. The therapy must be used to improve or restore speech/language deficits, cognitive communication, swallowing function, or improve speech/language development disorders.
3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to the receipt of services.

D. Chiropractic Services

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

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

ARTICLE XI. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. 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 the Plan Participant, to the nearest Hospital capable of providing services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care;
- (2) for the 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;
- (3) for the Temporarily Medically Disabled Mother of the ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.

b. Non-Emergency Transport

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

The Plan Participant must meet all of the following criteria for bed-confinement:

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

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

2. Ground Ambulance Services Without Transport

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

3. Air Ambulance Transport Services:

a. Emergency Transport

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

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

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

b. Non-Emergency Transport

Non- Emergency air Ambulance Service situations require prior Authorization from the Company. If Authorization is not obtained prior to services being rendered, the services will not be covered.

If Authorized by the Company before services are rendered, Benefits for Non-Emergency air Ambulance Services are available for Plan Participants, to the nearest facility or Hospital capable of providing services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care.

Once Authorized, it is recommended that the Plan Participant verify the Network participation status of the air Ambulance Provider in the state or area the point of pick up occurs, based on zip code. To locate a Participating Network Provider in the state or area where You will be receiving services, please call 1-800-810-2583 or go to the Blue National Doctor & Hospital Finder at <http://provider.bcbs.com>. Search for an air Ambulance Provider by using the point of pick up zip code in the search criteria.

4. Ambulance Service Benefits will be provided as follows:

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

B. 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.

C. Autism Spectrum Disorders

Autism Spectrum Disorders Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Habilitative or Rehabilitative Care, pharmacy care, psychiatric care, psychological care, and the therapeutic care.

Autism Spectrum Disorders Benefits are subject to the Copayments, Deductible amounts and Coinsurance that are applicable to the Benefits obtained. Example: A Plan Participant obtains speech therapy for treatment

of Autism Spectrum Disorders. The Plan Participant will pay the applicable Copayment, Deductible amounts or Coinsurance shown on the Schedule of Benefits.

D. Bone Mass Measurement

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

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

Copayments, Deductible amounts and Coinsurance are applicable.

One (1) osteoporosis screening per Benefit Period may be available to women age 65 and older or younger postmenopausal women at risk, under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Preferred Provider.

E. BRCA1 and BRCA2 Genetic Testing

Genetic testing of BRCA1 and BRCA2 genes will be covered to detect an increased risk of breast and ovarian cancer when recommended by a healthcare provider in accordance with the United States Preventive Services Task Force recommendations for testing.

Genetic testing of BRCA1 and BRCA2 genes may be available to women at an increased risk, under the Preventive or Wellness care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Preferred Provider.

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

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

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

2. Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of the long-term survivorship care. Plan Participants eligible for screenings are those who
 - a. were previously diagnosed with breast cancer;
 - b. completed treatment for breast cancer

- c. underwent bilateral mastectomy; and
- d. were subsequently determined to be clear of cancer.

These covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with the attending Physician and the Plan Participant. Annual preventive cancer screenings under this Benefit will be subject to any Copayments, Deductible amounts and Coinsurance.

G. Cleft Lip and Cleft Palate Services

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

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

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

H. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other life-threatening disease or condition. Coverage will be subject to any applicable terms, conditions and limitations that apply under this Benefit Plan, including Copayments, Deductible amounts and Coinsurance.
2. A "Qualified Individual" under this section means a Plan Participant that:
 - a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition;
 - b. And either,
 - (1) The referring healthcare professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the requirements in paragraph a, above; or
 - (2) The Plan Participant provides medical and scientific information establishing that the Plan Participant's participation in such trial would be appropriate based upon the Plan Participant meeting the conditions described in paragraph a, above.

3. An "Approved Clinical Trial" for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition 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 (1) through (4) above, 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 disease 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.

I. Diabetes Benefits

1. Diabetes Education and Training for Self Management

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

2. Diabetic Retinal Screening

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

J. Dietitian Visits

Benefits are available for visits to registered dietitians.

Dietitian visits for diabetics are available under a separate Benefit for diabetes education and training for self-management training and education.

K. Disposable Medical Equipment and Supplies

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

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered subject to the Deductible and applicable Coinsurance shown on the Schedule of Benefits. Continuous Glucose Monitors and accessories are covered.

1. Durable Medical Equipment

- a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be provided mainly for the comfort or convenience of the Plan Participant or others. In addition, the equipment must meet all of the following criteria:

- (1) it must withstand repeated use;
- (2) it is primarily and customarily used to serve a medical purpose;
- (3) it is generally not useful to a person in the absence of illness or injury; and
- (4) it is appropriate for use in the patient's home.

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

- (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge).
- (2) At the Plan's option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.
- (3) When Durable Medical Equipment is approved by Us, Benefits for standard equipment will be provided toward any deluxe equipment.

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

- (a) that do not serve a medical purpose;
 - (b) that are not required to complete daily living activities;
 - (c) that are solely for the Plan Participant's comfort or convenience; or
 - (d) that are not determined by Us to be Medically Necessary.
- (4) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.
 - (5) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or replacement of equipment damaged due to neglect or misuse will not be covered. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Benefit Plan will not be covered. Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or replacement of equipment damaged due to neglect or misuse will not be covered. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Benefit Plan will not be covered. Regardless of Medical Necessity, repair, adjustment or replacement of equipment subject to a recall within five (5) years after purchase or rental will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment will not be covered when provided under warranty.

c. Limitations in connection with Durable Medical Equipment.

- (1) There is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.
- (2) There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.
- (3) There is no coverage for replacement of equipment lost. There is no coverage for repair or replacement of equipment damaged due to neglect or misuse.
- (4) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by the Claims Administrator.
- (5) Regardless of Claims of Medical Necessity, deluxe equipment or deluxe features and functionalities of equipment that are not approved by Us are not covered.

2. Orthotic Devices

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

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.
- b. Repair or replacement of the Orthotic Device is covered only within a reasonable time - period from the date of purchase subject to the expected lifetime of the device. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of the device will not be covered when provided under warranty or when the device is subject to a recall.
- c. When Orthotic Devices are approved by Us, Benefits for standard devices will be provided toward any deluxe device.
 - (1) Deluxe devices or deluxe features and functionalities of devices are those:
 - (a) that do not serve a medical purpose;
 - (b) that are not required to complete daily living activities;
 - (c) that are solely for the Plan Participant's comfort or convenience; or
 - (d) that are not determined by us to be Medically Necessary.
 - (2) Regardless of Claims of Medical Necessity, deluxe devices or deluxe features and functionalities of devices that are not approved by Us are not covered.
- d. No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

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

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

- b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time- period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time- period. Regardless of Medical Necessity repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.
- c. When Prosthetic Appliances or Devices are approved by Us, Benefits for standard appliances or devices will be provided toward any deluxe appliance or devices.
 - (1) Deluxe appliances or devices or deluxe features and functionalities of devices are those:
 - (a) that do not serve a medical purpose;
 - (b) that are not required to complete daily living activities;
 - (c) that are solely for the Plan Participant's comfort or convenience; or
 - (d) that are not determined by us to be Medically Necessary.
 - (2) Regardless of Claims of Medical Necessity, deluxe appliances or devices or deluxe features and functionalities of devices that are not approved by Us are not covered.

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

Benefits will be available for the purchase of Prosthetic Appliances and Devices and Prosthetic Services of the limbs that the Claims Administrator Authorizes, and are covered subject to the following:

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

M. Gene Therapy and Cellular Immunotherapy Benefits

Gene Therapy and Cellular Immunotherapy are high cost, specialized treatments administered by a limited number of trained and quality Providers. Benefits are available for these services only:

1. When Written Authorization of Medical Necessity is given by the Company prior to services being performed; and
2. Services are performed at an Administrating Facility that has received prior written approval from Company to perform Your procedure.

N. Genetic or Molecular Testing for Cancer

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

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

O. Home Health Care Benefits

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

Coverage for Home Health Care services is subject to limitations as shown in the Schedule of Benefits.

P. Hospice Benefits

Hospice Care is covered.

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

Low Protein Food Products for treatment of certain Inherited Metabolic Diseases are covered. "Inherited Metabolic Disease" shall mean a disease caused by an inherited abnormality of body chemistry. "Low Protein Food Products" shall mean those foods that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low Protein Food Products shall not include natural foods that are naturally low in protein. Benefits for Low Protein Food Products are limited to the treatment of the following diseases:

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

R. Low Tech Imaging, Lab Tests and High-Tech Imaging

1. The Plan Participant will pay the Deductible and Coinsurance when he visits a Network/Non-Network Provider. Medically Necessary x-rays, lab tests, and machine tests are covered at one hundred percent (100%) of the Allowable Charge, when performed within the office or clinic of a Network Provider. Lab tests are also covered at one hundred percent (100%) of the Allowable Charge when performed by an independent laboratory that is a Network Provider. X-rays, lab tests, and machine tests taken, performed or processed in an Outpatient Facility or other setting are subject to the Deductible Amount and applicable Coinsurance. Lab tests that are taken, performed, or processed by a Non-Network Provider are subject to the Deductible and applicable Coinsurance.

High-Tech Imaging, including but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology, are subject to the Deductible and applicable Coinsurance.

S. Permanent Sterilization Procedures and Contraceptive Devices (Non-Permanent Sterilization)

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

Tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes are covered under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Network Provider.

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

IUDs are covered under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Network Provider.

T. 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 (2)-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.

Benefits are not subject to the Deductible Amount and Coinsurance.

U. Private Duty Nursing Services

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

Inpatient Private Duty Nursing Services are not covered.

V. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional claims are covered.

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

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

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

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

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

The amount Plan Participants pay for a Telehealth Services or Remote Patient Therapy visit may be different than the amount Plan Participants would pay for the same Provider's service in a non-Telehealth Services or non-Remote Patient Therapy services setting. Telehealth Services or Remote Patient Therapy services must be rendered by an EPO Network Provider.

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

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

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

X. Temporomandibular Joint Syndrome (TMJ)

Diagnosis, therapeutic, or surgical procedures related to Temporomandibular Joint Syndrome (TMJ) and associated musculature and neurological conditions. Services may require prior Authorization.

ARTICLE XII.

CARE MANAGEMENT

A. Selection of Provider, Penalties for Failure to Obtain Authorization, and Authorization of Admissions, Outpatient Services and Other Covered Services and Supplies

1. Selection of Provider

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

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

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

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

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

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

a. Admissions

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

(3) The Plan Participant remains responsible for the Deductible amount and applicable Coinsurance.

b. Outpatient Services, Other Covered Services and Supplies

(1) If a Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown in the Schedule of Benefits. The Plan Participant is responsible for all charges not covered.

(2) If a Non-Network Provider fails to obtain a required Authorization, the Plan will reduce Allowable Charges by the amount shown in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Plan Participant is responsible for all charges not covered and for the penalty amount.

(3) The Plan Participant remains responsible for any applicable Copayments, Deductible amounts and Coinsurance.

(4) If a service or supply was not Medically Necessary, the service or supply is not covered.

3. Authorization of Admissions

a. Authorization of Elective Admissions

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

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

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

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

b. Authorization of Emergency Admissions

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

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

c. Concurrent Review

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

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

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

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

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

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

B. Disease Management

1. Qualification

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

2. Disease Management Benefits

Our Disease Management programs are committed to improving the quality of care for Plan Participants as well as decreasing healthcare costs in populations with a chronic disease. The nurse works with Plan Participants to help them learn the self-care techniques they will need in order to manage their chronic disease, establish realistic goals for life style modification, and improve adherence to their Physician prescribed treatment plan. Blue Cross and Blue Shield of Louisiana is dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant.

C. Case Management

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

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

D. Alternative Benefits

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

ARTICLE XIII.

LIMITATIONS AND EXCLUSIONS

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

Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.

4. Benefits are excluded for services, Surgery, supplies, treatment, or expenses:
 - a. other than those specifically listed as covered by this Benefit Plan. Benefits are not payable for services a Plan Participant has no obligation to pay, or for which no charge or a lesser charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions;
 - b. rendered or furnished before the Plan Participant's Effective Date;
 - c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license;
 - d. paid or payable under Medicare Parts A or B when a Plan Participant has Medicare, except when Medicare Secondary Payer provisions apply;
 - e. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with the Claims Administrator's policies and procedures;
 - f. rendered as a result of occupational disease or injury compensable under any Workers' Compensation Law subject to the provisions of La. R.S. 23:1205(C) 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.
 - g. received from a dental, vision, or medical department or clinic maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
 - h. rendered, prescribed or otherwise provided by a Provider who is the Plan Participant, who is the Plan Participant's Spouse, child, stepchild, parent, stepparent or grandparent;
 - i. for telephone calls, video communication, text messaging, e-mail messaging, instant messaging or patient portal communications between the Plan Participant and their Provider unless specifically stated as covered under the Telehealth Services Benefit; for services billed with Telehealth codes not suitable for the setting in which the services are provided; for Telehealth Services not permitted by Claims Administrator, and for telehealth Services rendered by Providers not permitted by the Claims Administrator. Telehealth Services rendered by a BCBSLA network provider or a Non-Network Provider;
 - j. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Remote Patient Therapy services and devices unless the results are specifically required for a medical treatment decision for a Plan Participant or as required by law.
 - k. for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records of information required to adjudicate a Claim, or for access to or enrollment in or with any Provider;
 - l. for services performed in the home unless the services meet the definition of Home Health, or otherwise covered specifically in this policy, or are approved by Us;
 - m. for any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan; or

- n. for paternity tests and test performed for legal purposes.
5. Benefits are excluded for services in the following categories:
- a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
 - b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;
 - c. those occurring as a result of taking part in a riot or acts of civil disobedience;
 - d. those occurring as a result of a Plan Participant's commission or attempted commission of a felony; or
 - e. for treatment of any Plan Participant detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.
6. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses in connection with or related to, or Complications from the following:
- a. rhinoplasty;
 - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
 - c. gynecomastia;
 - d. Breast enlargement, except for breast reconstructive services as specifically provided in this Benefit Plan;
 - e. breast reduction, except for breast reconstructive services as specifically provided in this Benefit Plan or unless the estimated weight to be removed during breast reduction is greater than five hundred (500) grams excess breast tissue per breast to be reduced; the patient is not more than thirty percent (30%) over ideal body weight; and the Plan Participant has one of the following associated symptoms:
 - (1) back, neck, or shoulder pain;
 - (2) paresthesia of hands or arms in ulnar distribution; and/or;
 - (3) permanent shoulder grooving from bras straps;
 - 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;
 - 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;
 - h. diastasis recti;
 - i. biofeedback;
 - j. lifestyle/habit changing clinics and/or programs, except those the law requires Us to cover or those the Plan Administrator offer, endorse, approve, or promote as part of your healthcare coverage under this Benefit Plan. Some of these programs may be offered as a value-added services subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the program;

- k. Wilderness camp/programs are excluded except when provided by a qualified Residential Treatment Center and approved by Us as Medically Necessary for the treatment of mental health conditions or substance use disorders;
 - l. treatment related to erectile or sexual dysfunctions, low sexual desire disorder or other sexual inadequacies,;
 - m. Treatment related to sex transformations;
 - n. 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.;
 - o. recreational therapy;
 - p. primarily to enhance athletic abilities; and/or
 - q. Inpatient pain rehabilitation and Inpatient pain control programs.
7. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses related to:
- a. routine eye exams (except for those for diabetics shown in the Benefits section), eyeglasses or contact lenses or exams (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery);
 - b. eye exercises, visual training, or orthoptics;
 - c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;
 - d. hair pieces, wigs, hair growth, and/or hair implants;
 - e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser Surgery; or
 - f. visual therapy.
8. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses related to:
- a. any costs of donating an organ or tissue for transplant when a Plan Participant is a donor except as provided in this Benefit Plan;
 - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;
 - c. the transplant of any non-human organ or tissue;
 - d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan; or
 - e. Gene Therapy or Cellular Immunotherapy if prior Authorization is not obtained or if the services are performed at an administering Facility that has not been approved in writing by the Claims Administrator prior to services being rendered.
9. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any of the following, except as specifically provided for in this Benefit Plan or in the Schedule of Benefits:

- a. weight reduction programs;
 - b. Bariatric Surgery procedures including, but not limited to:
 - (1) Roux-en-Y gastric bypass;
 - (2) Laparoscopic adjustable gastric banding;
 - (3) Sleeve gastrectomy;
 - (4) Duodenal switch with biliopancreatic diversion;
 - c. removal of excess fat or skin, or services at a health spa or similar facility; or
 - d. obesity or morbid obesity.
10. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products or prescription donor human breast milk as described in this Benefit Plan.
11. Benefits are excluded for Prescription Drugs other than those administered during an Inpatient or Outpatient stay or those requiring parental administration in a Physician's office. The following Prescription Drugs are also excluded:
- a. Any medication not proven effective in general medical practice;
 - b. 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 the Claims Administrator;
 - c. Fertility Drugs;
 - d. Minerals and vitamins, except for vitamins requiring a prescription for dispensation and administered during a Hospital stay or in a Physician's office.
 - e. Nutritional or dietary supplements, or herbal supplements and treatments, except those required to be covered by the United States Preventive Service Task Force preventive services recommendations;
 - f. Prescription Drug products that contain marijuana, including medical marijuana;
 - g. 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;
 - h. Prescription Drugs for and/or treatment of idiopathic short stature;
 - i. Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider.
 - j. Covered Prescription Drugs that typically require administration by a healthcare professional are covered under the medical benefit when obtained from a healthcare professional;
 - k. Sales tax or interest.

12. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to a Plan Participant's home or vehicle.
13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for charges for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.
14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for palliative or cosmetic care or treatment of the foot. supportive devices of the foot and treatment of flat feet except for Medically Necessary Surgery.
15. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for routine foot care Benefits for a total of six (6) services, treatments or procedures for cutting or removing of corns and calluses are covered. Benefits for a total of six (6) services, treatments or procedures for nail trimming or debriding are covered. Benefits are limited for these services, treatments or procedures per Benefit Period whether such services, treatments or procedures in excess of this limit are not covered.
16. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any abortion other than to save the life of the mother.
17. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits.
18. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.
19. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child, except for services or treatment of an ectopic pregnancy or spontaneous abortion.
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 acupuncture when used to provide treatment for a condition or service that is excluded from coverage under this Benefit Plan.
23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Cosmetic Surgery, piercings, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly. Complications resulting from any of these items or any other non-covered items are excluded.
24. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under:
 - a. Oral Surgery Benefits
 - b. Cleft Lip and Cleft Palate Services

25. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for diagnosis, treatment, or Surgery of dentofacial anomalies, except as required by law, including, but not limited to:
 - a. malocclusion;
 - b. hyperplasia or hypoplasia of the mandible and/or maxilla; and
 - c. any orthognathic condition.
26. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.
27. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for travel expenses of any kind or type other than covered Ambulance Services to the closest hospital equipped to adequately treat the Plan Participant's condition, except as specifically provided in this Benefit Plan, or as approved by the Claims Administrator.
28. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Repatriation of remains from an international location back to the United States is not covered. Private or commercial air or sea transportation is not covered. Plan Participants traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to 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 exclusion for educational services and supplies does not apply to training and education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law.
30. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician's office.
31. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Custodial Care, nursing home care assisted living facility care or custodial home care, regardless of the level of care required or provided. This exclusion for Custodial Care applies to Claims for Private Duty Nursing Services that are determined by Us to be Custodial Care.
32. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Hospital charges for a well newborn, except as specifically provided in this Benefit Plan.
33. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for counseling services such as 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 by Preventive or Wellness Care or when required by law.
34. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for medical and Surgical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).
35. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for reversal of a voluntary sterilization procedure.
36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by the Claims Administrator. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by the Claims Administrator.

37. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a covered Plan Participant related to:
- a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or as required by law;
 - b. pre-implantation genetic diagnosis;
 - c. preconception carrier screening; and
 - d. prenatal carrier screening except screenings for cystic fibrosis.
38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Applied Behavior Analysis.

ARTICLE XIV. CONTINUATION OF COVERAGE RIGHTS

A. COBRA Continuation

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

What is COBRA continuation coverage?

In accordance with COBRA law, the employees and eligible dependents of certain employers may have the opportunity to continue their employer-sponsored healthcare coverage for a limited time, when there is a life event (also known as a “qualifying event”) that would otherwise result in the loss of coverage under the employer’s plan. When a qualifying event causes such loss of coverage, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” The Plan Participant, the Plan Participant’s Spouse and his Dependent children are listed under the law as the qualified beneficiaries. COBRA continuation coverage offers the same coverage that the Plan gives to other Plan Participants or beneficiaries who are not receiving continuation coverage. The qualified beneficiary may be required to pay the full cost of the continuation coverage for its entire duration.

Do I have other alternatives to COBRA continuation coverage?

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

For example, You could qualify to buy individual coverage through the Health Insurance Marketplace. Losing coverage under this Benefit Plan gives You a special enrollment opportunity in the Marketplace, even when it happens outside of the Marketplace’s Open Enrollment Period. You have sixty (60) days from when You lose coverage under this Benefit Plan to apply for special enrollment through the Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special enrollment opportunity for the Marketplace, and You will not be able to enroll until the Marketplace’s normal enrollment period opens or Your COBRA continuation coverage is exhausted.

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

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

What if I choose to get COBRA continuation coverage?

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

What are the “qualifying events”?

A “qualifying event” is any of the following events:

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

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

Do I have to provide notification of any qualifying event?

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

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

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

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

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

- begins no later than the date on which a Plan Participant would otherwise lose coverage under the Group health plan (the “coverage end date”); and
- ends sixty (60) days after the coverage end date or sixty (60) days after the Plan Participant is notified of their right to continue coverage, whichever is the latest.

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

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

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

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

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

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

Can I extend my COBRA continuation coverage?

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

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

If a qualified beneficiary experiences a second qualifying event other than the termination of employment or reduction of work hours while receiving eighteen (18) months of COBRA continuation of coverage, the

Dependents who were qualified beneficiaries at the time of the first qualifying event, and elected COBRA continuation coverage, may qualify for up to eighteen (18) additional months of continuation of coverage, for a maximum of thirty-six (36) months. This extension may be available to Dependents receiving continuation of coverage if:

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

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

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

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

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

Keep Your Plan Informed of Address Changes

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

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

Employees going on a military leave of absence to perform "service in the United States uniformed services" (as that term is defined under USERRA) may elect to continue coverage under this Benefit Plan for up to 24 months from the date that the Employee leaves for service. Only a covered Employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the Plan immediately before him/her leaving for military service. Dependents do not have any independent right to elect USERRA continuation coverage.

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

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

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

1. The Employee fails to pay the required premiums timely, or
2. The day after the date on which the Employee is required under the law to apply for or return to a position of employment and fails to do so.

USERRA continuation coverage rights may be provided concurrently with COBRA continuation coverage, as allowed by law.

If You wish to elect this coverage or obtain more detailed information, contact the Plan Administrator.

ARTICLE XV. COORDINATION OF BENEFITS

A. Applicability

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

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

B. Definitions (Applicable only to this 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 Plans covering a Plan Participant. The following are examples of services or expenses that are and not Allowable Expenses.
 - a. A healthcare service or expenses or a portion of a service or expense that is not covered by any of the Plans covering a Plan Participant is not an Allowable Expense.
 - b. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.
 - c. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the plans provides coverage for private hospital room expenses.
 - d. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charge 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 on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable Expense for all Plan.
 - 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 those types of Plan

provisions include second surgical opinions, prior Authorization of admissions and preferred provider arrangements.

2. Closed Panel Plan A plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.
3. Coordination of Benefits or COB - A provision establishing an order in which Plans pay their claims and permitting Secondary Plans to reduce their benefits so that the combined benefits of all Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. The COB provision applies to the part of the Benefit Plan providing healthcare Benefits which may be reduced because of the benefits of other Plans. Any other part of the Benefit Plan providing healthcare Benefits is separate from this Benefit Plan. This Benefit Plan may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits.
4. Custodial Parent
 - a. the parent awarded custody of a covered child by a court decree; or
 - b. in the absence of a court decree, the parent with whom the covered child resides more than one half of the calendar year without regard to any temporary visitation.
5. Order of Benefit Determination Rules – Rules that determine whether this plan is a Primary Plan or Secondary Plan when a Plan Participant has healthcare coverage under more than one Plan. When this Benefit Plan is Primary, We determine payment for Benefits first before those of any other Plan and without considering any other Plan's benefits. When this Benefit Plan is Secondary, We determine Benefits after those of another Plan and may reduce the Benefits We pay so that all Plan benefits do not exceed one hundred percent (100%) of the total Allowable Expense.
6. Plan - Any of the following that provide benefits or services for medical or dental care or treatment. If separate Plans are used to provide coordinated coverage for members of a group, the separate Plans are considered parts of the same Plan and there is no COB among those separate Plans.
 - 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 and traditional automobile or contracts; and
 - (6) Medicare or any other governmental benefits, as permitted by law,
 - b. Plan does not include:
 - (1) Hospital indemnity coverage benefits or other fixed indemnity coverage;
 - (2) Accident only coverage;
 - (3) Specified disease or specified accident coverage;

- (4) Limited benefit health coverage such as disability income, specified disease, vision;
- (5) School accident-type coverages with certain exceptions;
- (6) Benefits for non-medical components of long-term care contracts;
- (7) Medicare supplement policies;
- (8) Medicaid plans; or
- (9) coverage under other government Plans, unless permitted by law. Each contract for coverage under 6(a) or (b), above, is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

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

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

C. Coordination of Benefits and Order of Benefit Determination

- 1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:
 - a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
 - 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, 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.
 - d. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination Rules 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, has benefits determined before those of that Secondary Plan.
 - e. Except as provided in (f), below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this section is always Primary unless the provisions of both Plans state that the complying Plan is primary.
 - f. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medial coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

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

- a. Non-Dependent or Dependent provision

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

- b. Dependent Child Covered Under More than One Plan Provision

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

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

- (3) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraphs (3)(b)(1) or (3)(b)(2), above, shall determine the order of benefits as if those individuals were the parents of the child.
- (4) For a dependent child covered under the spouse's Plan:
 - (a) For a dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a dependent under a spouse's Plan, the Longer or Shorter Length of Coverage Provision, below, applies.
 - (b) In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits will be determined by applying the birthday provision above in (3)(b)(1) to the child's parent(s) and the spouse.

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

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

d. COBRA or State Continuation Coverage Provision

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the persons 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 determines 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 combine the amount paid by the Primary Plan the total Benefits paid or provided by all Plans for the Claims do not exceed the total Allowable Expense for that Claim. In addition, as the Secondary Plan, we will credit to the Benefit Plan Deductible Amount any amounts We would have credited to the Deductible Amount in the absence

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

2. 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.

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 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, Your Plans follow a procedure called Coordination of Benefits to determine how much each Plan 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 covered 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 COB rules will always be Primary.

3. When this Benefit Plan is Primary

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

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

4. Other Situations

- a. We will be Primary when any other provisions of state or federal law require Us to be. When We are the Primary Plan, We will pay the Benefits in accordance with the terms of Your Benefit Plan, just as if You had no other healthcare coverage under any other Plan.

- b. We will be Secondary whenever the rules do not require Us to be Primary. When we are the Secondary Plan, We do not pay until 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) 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.

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 COV. We need to 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. If the excess amount is not received when requested, any Benefits due under this Benefit Plan will be reduced by the amount to be recovered until such amount has been satisfied.

1. "Allowable Expense" means any healthcare expense, including coinsurance or copayments, and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.
 - a. If a Plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the *Internal Revenue Code* of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the *Internal Revenue Code* of 1986.
 - b. An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.
 - c. Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.
 - d. The following are examples of expenses that are not Allowable Expenses.
 - (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
 - (2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.
 - (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - (4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the Provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the secondary plan to determine its benefits.
2. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.
3. "Claim" a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:
 - a. services (including supplies);
 - b. payment for all or a portion of the expenses incurred;
 - c. a combination of subsection a and b of this Subparagraph; or
 - d. an indemnification.
4. "Claim Determination Period or Plan Year" a period of not less than 12 consecutive months over which Allowable Expenses shall be compared with total benefits payable in the absence of COB to determine whether over insurance exists and how much each Plan will pay or provide.

- a. The claim determination period is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group or individual contract. A person is covered by a Plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.
 - b. As each claim is submitted, each Plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same claim determination period.
5. "Closed Panel Plan" a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.
 6. "Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA" coverage provided under a right of continuation pursuant to federal law.
 7. "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 total Allowable Expenses.
 8. "Custodial Parent"
 - a. the parent awarded custody of a child by a court decree; or
 - b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
 9. "Group Insurance Contract" means an insurance policy or coverage that is sold in the group market and that are usually sponsored by a person's employer, union, employer organization or employee organization.
 10. "Group-Type Contract" a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the Plan Participant since the Plan Participant would have the right to maintain or renew the policy independently of continued employment with the employer.
 11. "High-Deductible Health Plan" the meaning given the term under section 223 of the *Internal Revenue Code* of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.
 12. "Hospital Indemnity Benefits" benefits not related to expenses incurred. Hospital indemnity benefits does not include reimbursement-type benefits even if they are designed or administered to give the Plan Participant the right to elect indemnity-type benefits at the time of claim.
 13. "Individual Insurance Contract" means an insurance policy or coverage that is sold to an individual and/or his/her family in the individual market.
 14. "Plan" a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its Benefit Plan shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the Benefit Plan uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this Subsection.

- a. Plan includes:
 - (1) Group Insurance Contracts, Individual Insurance Contracts and Subscriber contracts;
 - (2) Uninsured arrangements of group or Group-Type coverage;
 - (3) Group and non-group coverage through closed panel plans;
 - (4) Group-Type Contracts;
 - (5) the medical care components of long-term care contracts, such as skilled nursing care;
 - (6) the medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts;
 - (7) Medicare or other governmental benefits, as permitted by law, except as provided in Subparagraph b of this definition. That part of the definition of “Plan” may be limited to the hospital, medical and Surgical benefits of the governmental program; and
 - (8) group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

- 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 in La. R.S. 22:47(2)(c), except for group and non-group dental coverage;
 - (5) school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis;
 - (6) benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
 - (7) Medicare supplement policies;
 - (8) a state plan under Medicaid; or
 - (9) a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

- 15. “Policyholder or Subscriber” means the primary insured (Plan Participant) named in an Individual Insurance Contract.

- 16. “Primary Plan” a plan whose benefits for a person’s healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:
 - a. the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or
 - b. all plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

17. "Provider" a healthcare professional or healthcare facility.
18. "Secondary Plan" a plan that is not a primary plan.
19. "This Plan" means the part of this Benefit Plan and any amendments/endorsements thereto that provides Benefits for healthcare expenses.

I. Order of Benefit Determination Rules

1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:
 - a. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
 - (1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this Section is always primary unless the provisions of both Plans state that the complying plan is primary.
 - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-Network benefits.
 - b. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
 - c. When a person is covered under a group Plan and a non-group (individual) Plan, the non-group Plan is always secondary to any group Plan, disregarding any other provision of this Section.
2. The following rules apply when group Plans coordinate benefits among themselves, and when non-group ("individual") Plans coordinate benefits among themselves. Each Plan determines its order of benefits **using the first of the following rules that applies, and discarding any other successive rules:**
 - a. Non-Dependent or Dependent Rule. The Plan that covers the person other than as a dependent, for example the plan that covers a person as an employee, member, policyholder, Plan Participant, Subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, Plan Participant, Subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - b. Dependent Child Covered Under More Than One Plan Rule. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (a) The Plan of the parent whose Birthday falls earlier in the calendar year is the Primary plan;
or
 - (b) If both parents have the same Birthday the Plan that has covered the parent the longest is the Primary plan.

- (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - (b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits;
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits; or
 - (4) 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.
 - (5) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraphs (2)(b)(1) or (2)(b)(2) above shall determine the order of benefits as if those individuals were the parents of the child.
 - (6) For a dependent child covered under the Spouse's plan:
 - (a) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a Spouse's plan, the rule in Subparagraph (2)(e) (Longer or Shorter Length in Coverage) applies.
 - (b) In the event the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule above in Subparagraph (2)(b)(1) to the dependent child's parent(s) and the dependent's Spouse.
- c. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) can determine the order of benefits.
 - d. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, Plan Participant, subscriber or retiree or covering the person as a dependent of an employee, member, Plan Participant, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) determine the order of benefits.

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

To determine the length of time a person has been covered under a Plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

The start of a new Plan does not include:

- (1) a change in the amount or scope of a Plan's benefits;
- (2) a change in the entity that pays, provides or administers the Plan's benefits; or
- (3) a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

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

J. When This Plan is Secondary

Whenever This Plan is secondary to any other Plan, the Benefits of This Plan may be reduced so that no more than the Allowable Expense is ever paid for any given Claim taking into account all the benefits payable to the Plan Participant under all his/her Plans and sum of the Allowable Expenses for any Claim Determination Period. This will apply whether or not a Claim is made. The Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the Benefits of This Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of This Plan. In any event, This Plan will never pay more than it would have paid had it been the Primary plan.

K. Right to Receive and Release Needed Information

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

L. Facility of Payment

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

M. Right of Recovery

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

- 1. the persons We have paid or for whom We have paid;

2. insurance companies; or
3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. If the excess amount is not received when requested, any Benefits due under This Plan will be reduced by the amount to be recovered until such amount has been satisfied.

ARTICLE XVI. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

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

A. The Benefit Plan

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

B. Amending and Terminating the Benefit Plan

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

C. Identification Cards and Benefit Plans

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

D. Benefits to Which Plan Participants are Entitled

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Benefit Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.
2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.
3. Continuity of healthcare services.
 - a. Upon the termination of a contractual agreement with a Provider, notification of the removal of the Provider from the Preferred Network will be given to any Plan Participant who has begun a course of treatment by the Provider.
 - b. A Plan Participant who is a continuing care patient has the right to continuity of care until the earlier of the completion of the course of treatment or ninety (90) days after the Plan Participant is notified that the Provider has left the Preferred Network.
 - c. A continuing care patient is one who is:
 - (1) Undergoing a course of treatment for a Serious and Complex condition;
 - (2) Undergoing a course of institutional or Inpatient care;
 - (3) Scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care;
 - (4) Pregnant and undergoing a course of treatment for the pregnancy; or
 - (5) Terminally ill, which means the medical prognosis is a life expectancy of 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 the 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 the termination of a Provider's contractual agreement is a result of fraud.
 - (3) The Plan Participant voluntarily chooses to change Providers.

- (4) The Plan Participant relocates to a location outside of the geographic service area of the Provider of the Preferred Network.
- (5) The Plan Participant's condition does not meet the requirement to be deemed a Serious and Complex Condition.

E. Termination of a Plan Participant's Coverage

1. The Plan may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment. All representations made are material to the issuance of this coverage. Any information intentionally omitted from the enrollment form as to any proposed or covered Plan Participant, shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective date of coverage or terminated within three (3) years of the Plan Participant's Effective Date, for fraud or intentional misrepresentation of material fact. The Plan will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section.
2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, coverage for the Employee and/or any Dependents terminates as provided below:
 - a. The Employee's coverage and that of all his Dependents automatically terminates, without notice, at the end of the last day of the month employed as a full-time Employee or Full-Time Equivalent.
 - b. Coverage for the Employee's Dependents will also terminate automatically, without notice, on the following dates.
 - (1) Spouse – the date of final decree of divorce or other legal termination of marriage.
 - (2) Dependent child – end of the last day of the month the Dependent child turns age 26.
 - (3) Dependent grandchild – the end of the last day of the month the Dependent grandchild turns age 26.
 - c. Upon the death of an Employee, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if Employee contributions have been paid through that period. However, a surviving Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.
3. In the event the Group cancels this Benefit Plan, such cancellation or termination alone will operate to terminate all rights of the Plan Participant to Benefits under the terms of this Benefit Plan as of the effective date of such cancellation or termination. The Group shall have the obligation to notify its Plan Participants and beneficiaries of such cancellation or termination. The Claims Administrator shall have no such obligation of notification at the Plan Participant level.
4. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Plan Participant for Covered Services rendered after the date of termination of a Plan Participant's coverage.
5. The Claims Administrator reserves the right to automatically change the Plan Participant's class of coverage to reflect when no more Dependents are covered under this Benefit Plan.

F. Filing Claims

1. All Claims must be filed within ninety (90) days of 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 (12) months from the date services were rendered.

G. Applicable Law

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

H. 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.

I. Release of Information

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

J. Assignment

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

K. Plan Participant/Provider Relationship

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

L. This Benefit Plan and Medicare

1. For Employers having twenty (20) or more active Employees, federal law and regulations require that each active Employee age sixty-five (65) or older, and each active Employee's Spouse age sixty-five (65) or older, may elect to have coverage under this Plan or under Medicare.

- a. Where such Employee or such Spouse elects coverage under this Plan, this Plan will be the primary payor of Benefits with the Medicare program the secondary payor.
 - b. This Plan will not provide Benefits to supplement Medicare payments for Medicare eligible expenses for an active Employee age sixty-five (65) or older or for a Spouse age sixty-five (65) or older of an active Employee where such Employee or such Spouse elects to have the Medicare program as the primary payor.
2. Under federal law, if an active employee under age sixty-five (65) or an active employee's dependent under age sixty-five (65) is covered under a group benefit plan of an employer with one hundred (100) or more employees and also has coverage under the Medicare program by reason of Social Security disability, the group benefit plan is the primary payor and Medicare is the secondary payor.
 3. For persons under age sixty-five (65) who are covered under this Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Plan the secondary payor, except that during the first thirty (30) month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, this Plan will be the primary payor and Medicare the secondary payor.
 4. When this Plan is the primary payor, it will provide regular Benefits for Covered Services.

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

M. Notice

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

N. Job-Related Injury or Illness

The Group must report any job-related injury or illness of a Plan Participant to the appropriate federal or state governmental agency where so required under the provisions of any federal or state laws and/or related programs. This Plan, with any described exceptions, 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 whether or not coverage under such laws or programs is actually in force. In the event Benefits are initially extended by the Plan and a compensation carrier, employer, governmental agency or program, insurer or any other entity makes any type of settlement with the Plan Participant, or with any person entitled to receive settlement where the Plan Participant dies, or if the Plan Participant's injury or illness is found to be compensable under federal or state Workers' Compensation laws or programs, the Plan Participant must reimburse the Plan for Benefits extended or direct the compensation carrier, employer, governmental agency or program, insurer or any other entity to make such reimbursement. The Group will be entitled to such reimbursement even if the settlement does not mention or excludes payment for healthcare expenses.

O. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Group will be subrogated and will succeed to the Plan Participant's right for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier even where such carrier

provides Benefits directly to a Plan Participant who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights.

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

P. Right of Recovery

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

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

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

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

R. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that the Claims Administrator is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Blue Cross and Blue Shield of Louisiana and its subsidiaries and affiliates (collectively "Blue Cross and Blue Shield of Louisiana") to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that the Claims Administrator is not contracting as the agent of the Association. The Plan Administrator, on behalf of itself and its participants, further acknowledges and agrees that it has

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

S. Out-of-Area Services

The Claims Administrator 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 the geographic area Blue Cross and Blue Shield of Louisiana serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

1. BlueCard® Program

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

When You receive Covered Services outside of Blue Cross and Blue Shield of Louisiana's service area and the Claim is processed through the BlueCard® Program, the amount You pay for the Covered Services is calculated based on the lower of:

- the billed charges for Your Covered Services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for Your Claim because they will not be applied after a Claim has already been paid.

2. Special Case: Value-Based Programs

a. BlueCard® Program

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

b. Negotiated (non-BlueCard® Program) Arrangements

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

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

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

4. Non-Participating Providers Outside Blue Cross and Blue Shield of Louisiana's Service Area

a. Plan Participant Liability Calculation

When Covered Services are provided outside of Blue Cross and Blue Shield of Louisiana's service area 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 the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, may govern payments for out-of-Network Emergency Medical Services.

b. Exceptions

In certain situations, the Claims Administrator may use other payment methods, such as billed charges for Covered Services, the payment the Claims Administrator would make if the healthcare services had been obtained within Blue Cross and Blue Shield of Louisiana's service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

c. Blue Cross Blue Shield Global® Core

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

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

(1) Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global® Core service center for assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if You paid in full at the time of service, You must submit a Claim to receive reimbursement for Covered Services. You must contact the Claims Administrator to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

(2) 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.

(3) Submitting a Blue Cross Blue Shield Global® Core Claim

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

T. Certificates of Creditable Coverage

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

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

The Claims Administrator shall provide to certain Plan Participants who have Prescription Drug coverage under this Benefit Plan, without charge, a written certification that their Prescription Drug coverage under this Plan is either creditable or non-creditable. Coverage is deemed creditable if it is at least as good as the standard Medicare Part D prescription drug benefit. Claims Administrator will provide these Certificates to covered Group Plan Participants who are eligible for Medicare Part D based upon enrollment data. The Plan Administrator is responsible for providing a certificate to applicants prior to the Effective Date of coverage for new Medicare-eligible persons that join this Plan.

The Claims Administrator will provide Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to covered Plan Participants at the following times, or as designated by law:

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

V. Continued Coverage During a Leave of Absence

1. Family Medical Leave

The Family Medical Leave Act (FMLA) allows eligible Employees to take up to twelve (12) weeks of unpaid FMLA leave in a 12-month period, 30-day extension allowed with Terrebonne General approval for the following reasons:

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

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

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

2. Disability Leave

When an Employee is not actively at work due to a health condition, Plan will maintain coverage for the Employee and any Dependents, as long as the Employee remains a bona fide Employee of the Group and required contributions are paid. If Group terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan Participant's Coverage."

3. Other Employer-Approved Leave of Absence

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

W. Compliance with HIPAA Privacy Standards

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

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

1. General

The Plan shall not disclose Protected Health Information to any Employees of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually

identifiable health information about the past, present or future physical or Mental Health or condition of an individual, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

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

3. Authorized Employees

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

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

4. Certification of Employer

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

- a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

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

The following Employees of the Terrebonne General Health System. workforce are designated as authorized to receive Protected Health Information from Terrebonne General Health System ("the Plan") in order to perform their duties with respect to the Plan:

Human Resources Director, Producer

X. Compliance with HIPAA Electronic Security Standards

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

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

Y. Our Right to Offer Premium Incentives

The Claims Administrator 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:

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

ARTICLE XVII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

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

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

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

An expedited Appeal process is available for situations where the time frame of a standard Medical Appeal would seriously jeopardize the life or health of a covered person, or jeopardize the covered person's ability to regain maximum function.

A. Complaint, Grievance and Informal Reconsideration Procedures

A quality of service concern addresses the Claims Administrator's services, access, availability or attitude and those of the Claims Administrator's Network Providers. A quality of care concern addresses the appropriateness of care given to a Plan Participant.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with Us or with Provider services. A quality of care concern addresses the appropriateness of care given to a Plan Participant, Our services, access, availability or attitude and those of Our Network Providers.

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

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with the Claims Administrator or with Provider services. If a Plan Participant does not feel their Complaint was adequately resolved or the Plan Participant wishes to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, the Plan Participant may call the Claims Administrator's customer service department. Send written Grievances to:

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

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

3. Informal Reconsideration

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

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

B. Standard Appeal Procedures

Multiple requests to appeal the same Claim, service, issue or date of service will not be considered at any level of review.

If the Plan Participant has questions or needs assistance putting the Appeal in writing, the Plan Participant may call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370.

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

The Claims Administrator will determine if the Plan Participant's Appeal is an administrative Appeal or a medical Appeal. There are two (2) levels of each Appeal, the first by the Claims Administrator or its designee, and the second by the Plan Administrator, Terrebonne General Health System.

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

The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in their Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in review of an Adverse Benefit Determination. The authorized

representative may be the Plan Participant's treating Provider, if the Plan Participant appoints the Provider in writing.

1. Administrative Appeals

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

a. First Level Administrative Appeals

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

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

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

Administrative Appeals should be submitted in writing to:

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

b. Second Level Administrative Appeals

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

Terrebonne General Health System
P.O. Box 6039
Houma, LA 70361

Requests submitted to the Claims Administrator will be forwarded to Terrebonne General Health System

2. Medical Appeals

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

a. First Level Medical Appeals (Internal)

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

Medical Appeals should be submitted in writing to:

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

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

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

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

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

b. Second Level Medical Appeals (External)

If the Plan Participant still disagrees with the determination of their claim, the Plan Participant or their authorized representative must send their written request for an External Appeal within four (4) months of receipt of the internal Appeal decision to:

Terrebonne General Health System
Attn: Michelle Rousseau
P.O. Box 6039
Houma, LA 70361

The Group will review and notify the Claims Administrator to proceed with an external Appeal conducted by a non-affiliated Independent Review Organization (IRO). Requests submitted to the Plan Administrator after four (4) months of receipt of the internal Appeal decision will not be considered. The Plan Participant is required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. Appeals submitted by a Provider will not be accepted without this form completed with Your signature.

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

The IRO decision is considered final and binding.

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

C. Expedited Appeals

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

availability of care, continued stay, or healthcare for a Plan Participant currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

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

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

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

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

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

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

1. Expedited Internal Medical Appeals

In these cases, We will make a decision no later than seventy-two (72) hours of Our receipt of the internal medical Expedited Appeal request that meets the criteria for an Expedited Appeal. In any case where the internal medical Expedited Appeal process does not resolve a difference of opinion between Us and the Plan Participant or the Provider acting on behalf of the Plan Participant, the Appeal may be elevated to an Expedited External Appeal. If the internal medical Expedited 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

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

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

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

1. Plan Participant cost-sharing and surprise billing protections for Emergency Medical Services;
2. Plan Participant cost-sharing and surprise billing protections related to care provided by Non-Network Providers at Network facilities;
3. Whether Plan Participants are in a condition to receive notice and provide Informed Consent to waive the NSA protections; and

4. Whether a Claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to Plan Participant cost-sharing and surprise billing.
5. Continuity of Care

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

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

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

1. NSA Internal Appeals

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

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

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

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

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

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

2. NSA External Appeals

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

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

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

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

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

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

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

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

ARTICLE I. CARE WHILE TRAVELING, MAKING PLAN CHANGES AND FILING CLAIMS

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

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of the Claims Administrator's local service offices, or from the home office of Blue Cross and Blue Shield of Louisiana. If the Plan Participant needs to submit documentation to the Claims Administrator, the Plan Participant may forward it to Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA 70898-9029, or to, 5525 Reitz Avenue, Baton Rouge, LA 70809.

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

A. How to Obtain Care While Traveling

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

1. In an Emergency, go directly to the nearest Hospital.
2. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest Preferred Network doctors and Hospitals.
3. Use a designated Preferred Provider to receive the highest level of Benefits.
4. Present the Plan Participant's ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.

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

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

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

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

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

C. How to File Claims for Benefits

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

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

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

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

D. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

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

2. Outpatient Department Claims

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

3. Emergency Room Claims

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

4. Nursing Services Claims

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

5. Durable Medical Equipment (DME) Claims

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

6. Mental Health and/or Substance Use Disorder Claims

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

7. Other Medical Claims

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

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

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

E. Claims Questions

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

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

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

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

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

ARTICLE II. RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator

The Terrebonne General Health System Employee Benefit Plan is the Benefit Plan of Terrebonne General Health System, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by Terrebonne General Health System to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position Terrebonne General Health System shall appoint a new Plan Administrator as soon as reasonably possible.

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

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

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

B. Duties of the Plan Administrator

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

C. Plan Administrator Compensation

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

D. Fiduciary

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

1. Fiduciary Duties

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

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

2. The Named Fiduciary

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

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

E. The Claims Administrator is not a Fiduciary

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

ARTICLE III. GENERAL PLAN INFORMATION

NAME OF PLAN: Terrebonne General Health System

NAME AND ADDRESS OF EMPLOYER/PLAN SPONSOR: Terrebonne General Health System
P.O. Box 6039
Houma, La 70361

EMPLOYER IDENTIFICATION NUMBER (EIN) 72-8880258

PLAN NUMBER (PN): 501

TYPE OF PLAN: Comprehensive Medical Benefit Plan

The Plan is a self-funded group health plan. Benefits are administered, on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administrative Services Agreement and the terms and conditions of the Plan.

FUNDING MEDIUM AND TYPE OF ADMINISTRATION:

The funding for the Benefits is derived from the general assets of the Employer and contributions made by covered Employees. Employee contributions are at a rate determined by the Plan Sponsor. The Plan is not insured.

PLAN ADMINISTRATOR: Terrebonne General Health System
P.O. Box 6039
Houma, La 70361

AGENT FOR SERVICE OF LEGAL PROCESS: Service for legal process may be made upon the Plan Administrator or if applicable, a Plan Trustee.

CLAIMS ADMINISTRATOR: Blue Cross and Blue Shield of Louisiana (BCBSLA)
5525 Reitz Avenue
Baton Rouge, LA 70809
(225) 295-3307

BCBSLA has been hired to process Claims under the Plan. BCBSLA does not serve as an insurer, but merely as a claims processor. Claims for Benefits are sent to BCBSLA. BCBSLA processes and pays Claims, then requests reimbursement from the Plan. Terrebonne General Health System is ultimately responsible for providing Plan Benefits, and not BCBSLA.

PLAN YEAR ENDS: December 31st

PLAN DETAILS:

The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any Benefits are described in the Plan.

FUTURE OF THE PLAN:

Although the Plan Sponsor expects and intends to continue the Plan indefinitely, the Group reserves the right to modify, amend, suspend, or terminate the Plan at any time.



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

Nondiscrimination Notice

Discrimination is Against the Law

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

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

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

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

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

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

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

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

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

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

Or

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

NOTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)

