



**Office of Group Benefits
Pelican HSA 775
For
State of Louisiana Plan Participants**

provided by



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NON-GRANDFATHERED

HEALTH BENEFIT PLAN

NOTICES

HEALTHCARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTHCARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE 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/OGB OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON THE BACK OF YOUR IDENTIFICATION (ID) CARD.

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

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

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

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

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

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

These covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as selected by You in consultation with Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to any Copayments, Deductible Amounts and Coinsurances.

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



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

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

PELICAN HSA 775

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

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

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

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

A. FACTS ABOUT THIS HEALTH PLAN

This Plan is a Consumer Driven Health Plan (CDHP). This CDHP coverage may be used in conjunction with a Health Savings Account (HSA), which is set up in the name of the Plan Participant through a financial institution. HSAs are portable, tax-advantaged savings accounts that act like a medical IRA. Unused money is rolled over from year to year, grows through interest and investments, and can be used to pay for a wide variety of health and wellness related products and services. The IRS has established eligibility rules for HSAs. Most adults who are covered by a Consumer Driven Health Plan, like this CDHP product, and who have no other first dollar health coverage except for preventive care, may establish an HSA. Plan Participants that choose to take advantage of the Benefits of health savings accounts should learn about the laws affecting HSAs. They may wish to consult a qualified tax or financial advisor to ensure that they are eligible to establish an HSA, that they understand what other types of health coverage they may have without violating the HSA rules, what expenses may be paid from the HSA, and the many tax benefits available to them if they properly comply with all IRS rules on HSA accounts.

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

PLAN PARTICIPANTS WHO GET CARE FROM PROVIDERS IN THEIR NETWORK WILL PAY THE LEAST FOR THEIR CARE AND GET THE MOST VALUE FROM THIS PLAN.

Most Benefits are subject to the Plan Participant's payment of a Deductible Amount as stated on the Schedule of Benefits. After payment of applicable Deductible Amounts, Benefits are subject to two (2) Coinsurances (for example: 80/20, 70/30). The Plan Participant's choice of a Provider determines what Coinsurance applies to the service provided. The Plan will pay the highest Coinsurance for Medically Necessary services when a Plan Participant obtains care from a Network Provider. The Plan will pay the lower Coinsurance level when a Plan Participant obtains Medically Necessary services from a Provider who is not in the Preferred Care PPO Network.

Effective January 1, 2016, all Deductible Amounts, Out-of-Pocket Amounts, Coinsurance, Copayments and annual limits (day and dollar) will start over, and all Benefits in this Plan will apply on a calendar basis.

B. THE 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 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 Network and render services to the Plan Participants. These Providers are called "Network Providers." Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's dental network.

To obtain the highest level of Benefit Payment available, the Plan Participant should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Network Provider before the service is rendered. Plan Participants may review a current paper Provider directory or search for a provider outside of the state of Louisiana under National Provider Directory in the Find Care section of www.bcbsla.com/ogb or on the free BCBSLA app for Your iPhone or Android. Plan Participants may also contact the Plan's customer service department at the number listed on their ID card.

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 as a Network Provider when providing services at one location, and may be considered Non-Network when rendering services from another location. The Plan Participant should check his Provider directory to verify that the Provider is In-Network at the location where the Plan Participant is seeking care.

Additionally, Providers in Your network may be contracted to perform certain Covered Services, but may not be contracted in Your network to perform other Covered Services. When a Network Provider performs services that the Network Provider is not contracted with the Claims Administrator to perform (such as certain High-Tech 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 OF THE NETWORK

The PPO Network is an extensive network. However, Plan Participants choose which Providers will render their care, and Plan Participants may obtain care from Providers who are not in the PPO Network. However, the Plan pays a lower level of Benefit Payment when a Plan Participant uses a Provider outside of the Network. Benefit Payment may be based on a lower Allowable Charge, and/or a penalty may apply. Care obtained outside the Claims Administrator's Network means the Plan Participant has a higher Deductible and/or Coinsurance. In addition, the Plan Participant is responsible for the difference between the Allowable Charge and the billed charge. Therefore, Your Out-of-Pocket costs are greater than if You had stayed In-Network. THESE ADDITIONAL COSTS MAY BE SIGNIFICANT. The amount the Plan Participant is required to pay for services outside of Network does not accrue 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. Prior to obtaining care outside the Network, You should review the section titled "Sample Illustration of Plan Participant Costs When Using a Non-Network Hospital."

D. SAMPLE ILLUSTRATION OF PLAN PARTICIPANT COSTS WHEN USING A NON-NETWORK HOSPITAL

NOTE: The following example is for illustration purposes only and may not be a true reflection of the Plan Participant’s actual Deductible and Coinsurance amounts. 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 Network Hospitals and 70/30 Coinsurance when he receives Covered Services from Non-Network Hospitals. 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 Network Hospitals to render this service. There is no negotiated rate with the Non-Network Hospital.

The Plan Participant receives Covered Services from:	Network Hospital	Non- Network Hospital
Provider’s Bill:	\$12,000	\$12,000
Allowable Charge:	\$2,500	\$2,500
The Plan pays:	\$2,000 \$2,500 Allowable Charge x 80% Coinsurance = \$2,000	\$1,750 \$2,500 Allowable Charge x 70% Coinsurance = \$1,750
Plan Participant pays:	\$500 \$2,500 Allowable Charge x 20% Coinsurance = \$500	\$750 \$2,500 Allowable Charge x 30% Coinsurance = \$1,000
Plan Participant is billed up to the Provider’s billed charge	NO	YES
TOTAL PLAN PARTICIPANT PAYS:	\$500	\$10,250

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. The list of items and services that require Authorization can also be located on Our website, www.bcbsla.com/priorauth. See the Care Management Article of this Benefit Plan for additional information regarding Authorization requirements.

No payment will be made for Organ, and Bone Marrow Transplant Benefits or evaluations unless the Claims Administrator Authorizes these services and the services are rendered by a Blue Distinction Center for Transplants for the specific organ or transplant, or a transplant facility in the Blue Cross and Blue Shield of Louisiana PPO Network, unless otherwise approved by the Claims Administrator and the Plan Administrator in writing. Evaluation for Tissue Transplant is not required. 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.

In some cases, Network Benefits may be paid to Non-Network Providers whose services are not available by a Network Provider. Prior Authorization is required. The Network Benefits will be based on the Network Allowable Charge. The Plan Participant can be balance-billed by the Provider.

F. HOW WE DETERMINE WHAT WE PAY FOR THE PLAN PARTICIPANTS COVERED SERVICES

When the Plan Participant uses Network Providers

Network Providers are Providers who have signed a contract with Us to participate in the PPO 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 the Medically Necessary Covered Services Plan Participant who use Network Providers will receive Network Benefits and will pay the amounts shown in the PPO Network column on the Schedule of Benefits for these Covered Services.

When the Plan Participant uses Non-Network Providers

Non-Network Providers have not signed a contract with HMOLA Network, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plans. These Providers are not in Our Networks. We 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: The Claims Administrator has no fee arrangements with them.

We establish an Allowable Charge for Covered Services provided by Non-Network Providers. The Allowable Charge will be the lesser of the following:

- A. An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service.
- B. an amount We establish as the Allowable Charge; or
- C. the Provider's billed charge. You will receive a lower level of Benefit because You did not go to a Preferred Provider.

Plan Participants may pay significant costs when using Non-Network 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-Network Providers do not.

The Plan Participant has the right to file an Appeal with Us for consideration for Non-Emergency Medical Services performed at a Network facility unless the Provider issued the required written notice to the Plan Participant and has obtained the Plan Participant's consent to provide such 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 the Plan Participant and has obtained the Plan Participant's Informed Consent to provide such services.

G. WHEN A PLAN PARTICIPANT PURCHASES COVERED PRESCRIPTION DRUGS

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

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

To obtain contact information for the contracted specialty pharmacy, the Plan Participant should contact the Claims Administrator or the Claims Administrator's Pharmacy Benefit Manager at the telephone number indicated on His ID card.

H. ASSIGNMENT OR ATTEMPTED ASSIGNMENT

A Plan Participant's rights and Benefits under this Plan are personal to him and may not be assigned in whole or in part by the Plan Participant. The Claims Administrator will recognize assignments of Benefit Payments 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 Benefit Payment.

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 Network and Non-Network Providers directly instead of paying the Plan Participant.

I. PLAN PARTICIPANT INCENTIVES AND VALUE-ADDED SERVICES

Sometimes the Claims Administrator offers Plan Participants coupons, discounts, and incentives 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. We may also offer Plan Participants the opportunity to enroll in health and non-health related programs, as value-added services, to enhance the Plan Participant's experience with Us or his Providers. These incentives and value-added services are not Benefits and do not alter or affect Plan Participant Benefits. They may be offered by 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 without notice to Plan Participants.

J. 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.

K. CUSTOMER SERVICE

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/ogb and go to the box titled Contact Us. Click on Regional Office to find a regional office near You or click on Contact Information for Our customer service phone and fax numbers, and e-mail and postal addresses.

L. HOW TO OBTAIN CARE USING BLUECARD® 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:

- a. In an Emergency, go directly to the nearest Hospital.
- b. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest PPO Network Providers.
- c. Use a designated PPO Provider to receive Network Benefits.
- d. Present the Plan Participant's ID card to the Provider, who will verify coverage and file Claims for the Plan Participant. (Plan Participants may be required to pay Providers and seek reimbursement).
- e. The Plan Participant must obtain any required Authorizations from the Claims Administrator.

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands with a Blue Cross Blue Shield Global® Core Provider are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands from a non-Blue Cross Blue Shield Global® Core Provider ARE COVERED AT THE NON-NETWORK BENEFIT LEVEL.

ARTICLE II.

DEFINITIONS

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

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

Adverse Benefit Determination – Means denial or partial denial of a Benefit, in whole or in part, based on:

- A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment 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

Affordable Care Act (ACA and/or PPACA) - The Patient Protection and Affordable Care Act, a United States federal statute signed into law on March 23, 2010, together with the Health Care and Education Reconciliation Act of 2010, and other amending laws, as well as regulations validly promulgated pursuant thereto.

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

Allied Health Professional – A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, and/or approved by Us to render Covered Services. For coverage purposes under this Benefit Plan, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified midwives, registered Doulas, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, Physician Assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by 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 We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service.
 - 2. an amount We establish as the Allowable Charge; or
 - 3. the Provider's billed charge.

Alternate Facility – a healthcare facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

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 means of 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.

Amendment – Any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the Claims Administrator or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Enrollment – A period of time, designated by the Group, during which an Employee may enroll for Benefits under this Benefit Plan or any other Group Plan.

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

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

Authorization (Authorized) – A determination by the 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. If a required authorization is not obtained prior to services being rendered by a Network Provider, services are not covered, and the Provider cannot bill the Plan Participant for those services that require a Prior Authorizations. If a service is being rendered by a Non-Network Provider and any required authorization has not been obtained prior to services being rendered, benefits otherwise payable will be reduced to fifty percent (50%).

Authorized Representative – A person, including the Participant's treating Provider, to whom the Plan Participant has given written consent to represent the Plan Participant in a review of an Adverse Benefit

Determination.

Autism Spectrum Disorders (ASD) – Any of the pervasive neurobiological development disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM). These disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. Autism Spectrum Disorders includes conditions such as Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and Pervasive Development Disorder Not Otherwise Specified. Applied Behavior Analysis is available for coverage for the treatment of Autism Spectrum Disorders when it is determined to be Medically Necessary.

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 Payment – Payment of Eligible Expenses based on the Allowable Charge, at the percentage shown on the Schedule of Benefits after applicable Deductibles, Copayments, and Coinsurance.

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

Benefit Plan – The health benefit program and any prescription drug or pharmacy benefits program or Formulary (to the extent any pharmacy or prescription drug benefit is provided under this Plan) established by the Group for Plan Participants.

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

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

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’s option administered by medical professionals, which focuses on unusually complex, difficult or catastrophic illnesses. Working with the Plan Participant’s Physician(s) and subject to consent by the Plan Participant and/or the Plan Participant’s family/caregiver, the Case Management staff will manage care to achieve the most efficient and effective use of resources.

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

Child or Children – includes:

- A. The issue of a marriage of the Employee.
- B. natural Child of the Employee.
- C. A legally adopted Child of the Employee or a Child placed for adoption with the Employee.
- D. The Child of a male Employee, if a court of competent jurisdiction has issued an order of filiation declaring the paternity of the Employee for the Child or the Employee has formally acknowledged the Child.
- E. The issue of a previous marriage or a natural or legally adopted Child of the Employee’s legal Spouse, hereinafter “stepchild”, which stepchild has not been adopted by the Employee and for whom the Employee does not have court-ordered legal custody.
- F. A grandchild in the court-ordered legal custody of and residing with the grandparent Employee, until the end of the month the grandchild attains the age of twenty-six (26).
- G. A Dependent for whom the Employee has court-ordered legal custody or court-ordered legal guardianship but who is not a Child or grandchild of the Employee, until the end of the month the custody or guardianship order expires or the end of the month the Dependent attains the age of eighteen (18), whichever is earlier;
or
- H. A grandchild or Dependent of a Dependent of the Employee whose parent is covered under the Plan as a Dependent, or a child for whom the Employee has current provisional custody, which grandchild/child has not been adopted by the Employee and for whom the Employee has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a “Child” as of December 31, 2015.

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 insured under this Benefit Plan. The provisions in effect at the time the service or treatment is received shall govern the processing of any Claim expense actually covered as a result of the service or treatment rendered.

Claims Administrator – The entity with whom the Group (Plan Administrator) 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/HMO Louisiana, Inc. (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 – The federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 with amendments.

Code – The Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.

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 Benefit Payment provided.

Company – Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. (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 Us, based on substantial medical literature and experience, to be a direct and consequential result of another medical condition, disease, service or treatment. Solely as an example, a pulmonary embolism after Surgery would be a Complication of the Surgery.

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

Convalescent/Maintenance Care or Rest Cure – Treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by one's self, family, or other caregivers who are not eligible Providers. The services are primarily designed to help the patient with daily living activities, maintain the patient's present physical and mental condition, and/or provide a structured or safe environment.

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

Covered Person – An Active Employee, his eligible Dependent(s), or any other individual eligible for coverage under the Schedule of Eligibility or state or federal law for whom the necessary application forms have been completed, for whom the required contribution has been made, and whom the Plan Administrator has accepted Eligibility and enrolled into the Plan. The term Covered Person, defined here, is used interchangeably with the term Plan Participant.

Covered Service – A service or supply specified in this Benefit Plan for which Benefits are available when rendered by a Provider. The health services are provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorder or their symptoms.

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to:

- A. Providing personal care, homemaking, moving the patient.
- B. Acting as companion or sitter.
- C. Supervising medication that can usually be self-administered.
- D. Treating or providing services that any person may be able to perform with minimal instruction; or
- E. Providing long-term treatment for a condition in a patient who is not expected to improve or recover during periods when the medical condition of the patient who requires the service is not changing.

The Claims Administrator determines which services are Custodial Care.

Date Acquired – The date a Dependent of a covered Employee is acquired in the following instance and on the following dates only:

- A. Spouse – the date of marriage.
- B. Child or Children:
 - 1. Natural Children – the date of birth.
 - 2. Children placed for adoption with the Employee:
 - Agency adoption – the date the adoption contract was executed between the Employee and the adoption agency.
 - Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee. The Plan Administrator must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first.
 - 3. Child for whom the Employee has court-ordered custody or court-ordered legal guardianship – the date of the court order granting legal custody or guardianship.
 - 4. From the date of the court order of filiation declaring paternity or the date of formal acknowledgment of the Child.
 - 5. Stepchild – the date of the marriage of the Employee to his/her Spouse.

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

Deductible Amount –

- A. Individual Deductible Amount – The dollar amount, as shown on the Schedule of Benefits, of Allowable Charges for Covered services, which a Plan Participant with Employee Only coverage must pay within a Benefit Period before the Plan starts paying benefits.

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

The Deductible Amount does not apply to Preventive and Wellness Care.

- B. Family Deductible Amount – The dollar amount, as shown on the Schedule of Benefits, of Allowable Charges for Covered Services, which may be paid by a family within a Benefit Period before the Plan starts paying Benefits. If the Benefit Plan includes more than one (1) Plan Participant, the Individual Deductible Amount is not applicable. The Family Deductible Amount applies. After the Family Deductible Amount is met, this Plan starts paying Benefits for all covered members of the family, for the remainder of the Benefit Period.

Network and Non-Network Benefit categories may each carry a separate Family Deductible Amount shown in the Schedule of Benefits.

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

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

Dependent – Any of the following persons who (a) are enrolled for coverage as Dependents by completing appropriate enrollment documents, if they are not also covered as an Employee, and (b) whose relationship to the Employee has been Documented, as defined herein:

- A. The covered Employee's Spouse.
- B. A Child from Date Acquired until end of month of attainment of age twenty-six (26), except for the following:
 - 1. A grandchild or Dependent of a Dependent of the Employee whose parent is covered under the Plan as a Dependent and for whom the Employee has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which grandchild or Dependent of a Dependent was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from the Date Acquired until the end of the month the parent Dependent Child is no longer enrolled on or eligible to participate in the Plan, the end of the month the grandchild or Dependent of a Dependent turns twenty-six (26), or the grandchild or Dependent of a Dependent no longer meets the eligibility requirements under this Plan, whichever is earlier;
 - 2. A Child for whom the Employee has current provisional custody and for whom the Employee has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which Child was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from the Date Acquired until the end of the month of the 2016 anniversary date of the existing provisional custody document, the end of the month the child reaches the age of eighteen (18), or December 31, 2016, whichever is earlier;
 - 3. A Child, who is not the Child or grandchild or the Employee, for whom the Employee has court-ordered custody or court-ordered legal guardianship/ but who has not been adopted by the Employee, from the

Date Acquired until the end of the month the custody/guardianship order expires or the end of the month the Child reaches the age of eighteen (18), whichever is earlier;

4. A stepchild of the Employee, which stepchild has not been adopted by the Employee and for whom the Employee does not have court-ordered legal custody, until the earliest of:
 - a. The end of the month the Employee is no longer married to the stepchild's parent.
 - b. The end of the month of the death of the Employee's Spouse who is the stepchild's parent; or
 - c. The end of the month the stepchild reaches the age of twenty-six (26).

C. A Child of any age who meets the criteria set forth in the Eligibility Article of this Benefit Plan.

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.

Disability – The Plan Participant, who is an Employee and is prevented, solely because of a disease, illness, accident, or injury, from engaging in his or her regular or customary occupation and is performing no work of any kind for compensation or profit; or a Dependent who is prevented from substantially engaging in all the normal activities of a person of like age in good health solely because of a disease, illness, accident, or injury.

Documented (with respect to a Dependent of an Employee) – The following written proof of relationship to the Employee has been presented for inspection and copying to the Group, or to a representative of the Employee's Participant Employer designated by OGB:

A. The covered Employee's Spouse - Certified copy of the certificate of marriage indicating the date and place of marriage.

B. Child:

1. Natural or legally adopted Child of the Employee - Certified copy of the birth certificate listing Employee as parent or certified copy of the legal acknowledgment of paternity signed by the Employee, certified copy of the court order of filiation declaring paternity of the Employee or certified copy of the adoption decree naming the Employee as adoptive parent.
2. Stepchild - Certified copy of the certificate of marriage to the Spouse and the birth certificate or adoption decree listing the Spouse as natural or adoptive parent.
3. Child placed with Your family for adoption by agency adoption or irrevocable Act of Voluntary Surrender for private adoption. Certified copy of the adoption placement order showing the date of placement or copy of the signed and dated irrevocable Act of Voluntary Surrender.
4. Child for whom You have been granted court-ordered legal guardianship or court-ordered custody - Certified copy of the signed court order granting legal guardianship or custody.

C. Child age twenty-six (26) or older who is incapable of self-sustaining employment by reason of physical or mental disability who was covered prior to age twenty-six (26). No earlier than six (6) months prior to attaining age twenty-six (26) documentation as described in B.1. through B.4. above, together with an application for continued coverage must be filed with the Plan Administrator on a form designated by the Plan Administrator.

1. This application must be accompanied by an attestation from the Dependent Child's attending Physician setting forth the specific physical or mental disability and certifying that the Child is incapable

of self-sustaining employment by reason of that disability. The Plan Administrator may require additional medical or other supporting documentation regarding the disability to process the application.

2. After the initial approval, the Plan Administrator may require the submission of additional medical or other supporting documentation substantiating the continuance of the disability, but not more frequently than annually, as a precondition to continued coverage.

D. Such other written proof of relationship to the Employee deemed sufficient by the Group.

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

Durable Medical Equipment – Items and supplies which are used to serve a specific therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are not disposable, 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 medical or Surgical care, for which a reasonable delay will not unfavorably affect the outcome of the treatment.

Eligible Expenses – the charges incurred for Covered Services.

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 and are not required to be covered as Emergency Medical Services.

Employee – A full-time Employee as defined by the respective Participant Employer in accordance with state law, and any Full-Time Equivalent, as defined herein.

Enrollment Date – The first date of coverage under this Benefit Plan.

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 internal review of an Adverse Benefit Determination, which involves any of the following situations:

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

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

- A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function.
- B. A decision not to 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 (IRO), to change an initial Adverse Benefit Determination made by the Claims Administrator or to change a final Adverse Benefit Determination rendered on Appeal. An External Appeal is available upon request by the Plan Participant or the Plan Participant's authorized representative for Adverse Benefit Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, Rescission, or for claims for which external review is provided under the No Surprises Act.

Formulary – The list of prescription drugs that are covered by the pharmacy benefits program established by the Office of Group Benefits and as amended from time to time. The Formulary may contain preferred and non-preferred tiers and may or may not be administered by the Claims Administrator.

Full Time Equivalent (FTE) – A full-time equivalent Employee who is employed on average thirty (30) or more hours per week, as defined under Code Section 4980H and determined pursuant to the regulations issued thereunder.

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

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

Gestational Carrier – A woman who agrees to engage in a process by which she attempts to carry and give birth to a child born as the result of an in-utero transfer of a human embryo to which she makes no genetic contribution.

Grievance – A written expression of dissatisfaction with the quality of care or services received from the Claims Administrator or a Network Provider.

Group – State of Louisiana Office of Group Benefits who is the Plan Administrator.

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

HIPAA – The Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and Federal Regulations promulgated pursuant thereto.

HIPAA Special Enrollment Event – An event as specified by federal law that entitles an Employee and the Employee's Dependents an opportunity to enroll in, and change, if desired, healthcare coverage offered by OGB outside of Annual Enrollment.

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. Hospice Care is 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 health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians. Nursing services are Provider twenty-four (24) hours per day. A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

iatrogenic fertility- Impairment of fertility caused directly or indirectly by Surgery, chemotherapy, radiation, or other Medically Necessary medical treatment affecting reproductive organs or processes.

Imaging Services – As described below and specific to this Plan:

Low-Tech Imaging – Includes x-rays that are not classified as High-Tech Imaging.

High Tech Imaging – Imaging Services which include, but are not limited to, MRI, MRAs, CT Scans, PET Scans and nuclear cardiology.

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

Independent Review Organization (IRO) – An entity, not affiliated with Us, that conducts external reviews of Adverse Benefit Determinations. Recission determinations and No Surprises Act related decisions. The decision of the IRO is binding on both the Plan Participant and Us, except to the extent the 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 service from the Non-Network Provider without the protections provided by the No Surprises Act.

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

Informal Reconsideration – A telephone request by the Plan Participant's Provider to the Claims Administrator's Medical Director, or to a peer reviewer for additional review of an adverse Utilization Management determination. An Informal Reconsideration is available only if requested within ten (10) calendar days of the date of the initial denial or adverse Concurrent Review determination.

Injury – Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

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.

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Intensive Outpatient Programs – An Outpatient treatment program that provides a planned and structured, intensive level of care of at least two (2) hours per day and three (3) days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a Mental Disorder and/or a substance use disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services include multiple or extended treatment/rehabilitation and counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some day treatment. Although treatment for substance use 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.

Intermediate Care – Mental Health or Substance Use Disorder treatment that encompasses one the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment Program.

- Care through an Intensive Outpatient Treatment Program.

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, 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; or

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

Medically Necessary (or Medical Necessity) – A service, treatment, procedure, equipment, drug, device, item, or supply, which, in the judgment of the Claims Administrator:

- A. Is appropriate and consistent with a Covered Person's diagnosis and treatment as well as with nationally accepted medical standards; and
- B. Is not primarily for personal comfort or convenience, Custodial Care, or Convalescent/Maintenance Care or Rest Cure.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

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

- A. Psychoses.
- B. Neurotic disorders.
- C. Personality disorders.
- D. Affective disorders.

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

- E. Schizophrenia or schizoaffective disorder.
- F. Bipolar disorder.
- G. Panic disorder.

- H. Obsessive-compulsive disorder.
- I. Major depressive disorder.
- J. Anorexia/bulimia.
- K. Intermittent explosive disorder.
- L. Post-traumatic stress disorder.
- M. Psychosis not otherwise specified when diagnosed in a Child under seventeen (17) years of age.
- N. Rett's Disorder.
- O. Tourette's Disorder, and
- P. 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) is 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 – A Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator.

Network Benefits – Benefits for Covered Health Services received from a Network Physician, Network facility, or other Network Provider.

Network Provider – A Provider that has signed an agreement with the Claims Administrator or another Blue Cross and Blue Shield plan to participate as a member of the PPO Network or another Blue Plan's PPO Network. This Provider may also be referred to as an In-Network Provider.

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

Non-Network Benefits – Benefits for Covered Health Services received from a Non-Network Physician, Non-Network facility, or other non-Network Provider.

Non-Network Provider – A Provider who is not a member of the Claims Administrator's PPO Network or another Blue Cross and Blue Shield plan PPO Network. This Provider may also be referred to as an Out-of-Network Provider.

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

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

Office of Group Benefits (OGB) – The entity created and empowered to administer the programs of benefits authorized or provided for under the provisions of Chapter 12 of Title 42 of the Louisiana Revised Statutes.

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

Out-of-Pocket Amount –

- A. Individual Out-of-Pocket Amount – The maximum amount, as shown on the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amounts and Coinsurance), which may be paid by a Plan Participant with Employee Only coverage, within a Benefit Period. After the Individual Out-of-Pocket is met, the Plan will pay one hundred percent (100%) of the Allowable Charge for Covered Services.

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

- B. Family Out-of-Pocket Amount – The maximum amount, as shown in the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amounts and Coinsurance), which may be paid by a family within a Benefit Period. If the Benefit Plan covers more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable Charge for Covered Services, for all covered members of the family, for the remainder of the Benefit Period, whether each member has met the Per Member within a Family Out-of-Pocket Amount.

Network and Non-Network Benefit categories may each carry a separate Family Out-of-Pocket Amount shown on the Schedule of Benefits.

- C. Per Member within a Family Out-of-Pocket Amount – The maximum dollar amount, shown on the Schedule of Benefits, of non-reimbursable expenses for Network Covered Services, which may be paid by one (1) family member within a Benefit Period. After the Per Member within a Family Out-of-Pocket Amount is met, the plan will pay one hundred percent (100%) of the Allowable Charge for Network Covered Services, for that family member, for the remainder of the Benefit Period. No family member may contribute more than the Per Member within a Family Out-of-Pocket Amount towards satisfaction of the Family Out-of-Pocket Amount.

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

Outpatient Surgical Facility – An Ambulatory Surgical Center licensed by the state in which services are rendered.

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

Partial Hospitalization Programs – Programs that provide structured and medically supervised day, evening and/or night treatment for at least four (4) hours per day and three (3) days per week, although some patients may need to attend less often. The services are of essentially the same nature and intensity (including medical

and nursing) as those provided in a Hospital except that patients are in the Hospital less than twenty-four (24) hours per day. Patients are not considered residents at the program. The range of services addresses a Mental Health and/or a Substance Use Disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

Participant Employer – A state entity, school board, or a state political subdivision authorized by law to participate in this Benefit Plan.

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

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

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

Plan – the health benefit program and any prescription drug or pharmacy benefits program or Formulary (to the extent any prescription drug or pharmacy benefit is provided under this Plan) established by the Group for Plan Participants.

Plan Administrator – Office of Group Benefits, who administers these Benefits on behalf of State of Louisiana, for eligible Employees and Dependents for Participant Employers.

Plan Participant – An Active Employee, his eligible Dependent(s), or any other individual eligible for coverage under the Schedule of Eligibility or state or federal law for whom the necessary application forms have been completed, for whom the required contribution has been made, and for whom the Plan Administrator has accepted Eligibility and enrolled into the Plan. The term Plan Participant, defined here, is used interchangeably with the term Covered Person.

Plan Year – The period from January 1, or the date the Plan Participant first becomes covered under the Plan, through December 31.

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

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

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

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

Preventive Services or Recommended Preventive Services – Healthcare services designed for promotion or maintenance of health and prevention of disease. Preventive Services include, but are not limited to, screening to identify people at risk of developing specific problems, counseling, health education, immunization programs and other necessary intervention to avert a health problem. This Plan provides Preventive Services Benefits in accordance with the following guidelines:

- A. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved.

Recommendations of the United States Preventive Services Task Force are not required to be covered immediately after the release of the recommendation or guideline. Timing rules apply by law.

- B. Immunizations for routine use in Children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- C. With respect to infants, Children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- D. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

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 the Plan Participants in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

- A. Preferred Provider (Preferred Care Provider) – A Provider who has entered into a contract with the Claims Administrator to participate in its Preferred Care PPO Network, as shown in the Schedule of Benefits. This Provider is also referred to as a Network Provider.
- B. Participating Provider – A Provider that has signed a contract with the Claims Administrator, or another Blue Cross and Blue Shield plan for other than the Preferred Care PPO Provider Network.
- C. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.
- D. Quality Blue Primary Care Provider – Any Provider who has signed a contract to participate in the Quality Blue Program. Currently Quality Blue Providers include family practitioners, general practitioners, pediatricians, internist, geriatricians, nurse practitioners and physician assistants, but more Providers may contract to participate in the Quality Blue program. To verify if a Provider participates in the Quality Blue program, 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.

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.

Recovery – With respect to Subrogation and Reimbursement, Recovery means any and all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for losses allegedly caused by injury or sickness, whether or not the losses reflect medical or dental charges covered by the Plan.

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

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.

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

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

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

Residential Treatment Center – A 24-hour, non-acute care treatment setting to actively treat specific impairments of Mental Health or Substance Use Disorders.

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

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

- A. For an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- B. For a chronic illness or condition, a condition that:
 - 1. Is 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 the Claims Administrator), 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 HIPAA Special Enrollment Event, including but not limited to, losing other comparable 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:

- A. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.
- B. Coordination of care is required prior to drug therapy initiation and/or during therapy.
- C. Unique patient compliance and safety monitoring requirements.
- D. Unique requirements for handling, shipping and storage.
- E. Restricted access or limited distribution.

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

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

Spouse – The Employee's Spouse pursuant to a marriage recognized under state law where the marriage was entered.

Subrogation and Reimbursement – The Plan's right to recover issued Benefit Payments for treatment of a Plan Participant's accident-related injuries.

Substance Use Disorder – A pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more criteria occurring within a 12-month period, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM). The definition of Substance Use Disorder shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

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 caesarean sections.
- D. usual and related pre-operative and post-operative care; or
- E. other procedures as defined and approved by the Plan.

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

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

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

Temporary Employee – An Employee who is employed for 120 consecutive calendar days or less.

Temporomandibular Joint (TMJ) Disorders – 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.

Transplant Acquisition Expense – A donor's medical expenses, for each transplant covered under this Plan.

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

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

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

Utilization Review Organization (URO) – An entity that has established one or more utilization review programs, which evaluates the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures, and facilities; sometimes referred to as Utilization Management.

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

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

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

ARTICLE III.

SCHEDULE OF ELIGIBILITY

Eligibility requirements in the OGB Benefit Plan apply to all participants in OGB-sponsored health plans and the OGB life insurance plan.

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

THE PLAN ADMINISTRATOR HAS FULL DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR COVERAGE/BENEFITS AND/OR TO CONSTRUE THE TERMS OF THIS PLAN.

NOTE: A Temporary Employee does not meet the Eligibility Requirements under this Benefit Plan, unless such Temporary Employee is determined to be an FTE.

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

A. Persons to be Covered

1. Employee

- a. A full-time Employee as defined by a Participant Employer and any FTE, both as determined in accordance with applicable state and federal law.
- b. Spouse, Both Employees - NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE. If a covered Spouse is eligible for coverage as an Employee and chooses to be covered separately at a later date, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase Benefits.
- c. Effective Dates of Coverage, New Employee, Transferring Employee, and FTE

Coverage for each Employee who completes the applicable enrollment form and agrees to make the required payroll contributions to his Participant Employer is effective as follows:

- (1) For new full-time Employees, if employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if hired on July 1st, coverage will begin on August 1st).
- (2) For new full-time Employees, if employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15th, coverage will begin on September 1st).
- (3) Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or special enrollment period.
- (4) An Employee who transfers employment to another Participant Employer must complete a transfer form within thirty (30) days following the date of transfer to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.
- (5) An Employee who is determined to be a FTE will be allowed to enroll in the Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for

those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth (13th) month of employment for those Employees determined to be FTEs during their initial measurement period.

- (6) Employee coverage will become effective concurrent with the date employment begins when required by state law during a federal or state declaration of Emergency involving risk to health of individuals employed by a public elementary or secondary school system.

d. Re-Enrollment for Health and/or Life Benefits

- (1) Full-time Employees returning to full time or part-time status with less than thirteen (13) weeks (less than 26 weeks for educational institutions) since separation or termination may resume coverage if application is made within thirty (30) days following return to work. Coverage will resume on the first of the month following return to work.
- (2) If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within thirty (30) days of re-employment.

e. Board and Commission Members

Except as otherwise provided by law, board and commission members are not eligible to participate in this Plan. This provision does not apply to members of school boards, state boards, or commissions as defined by the Participant Employer as full-time Employees.

f. Legislative Assistants

A legislative assistant is eligible to participate in the Plan if he or she is determined to be a full-time Employee by the Participant Employer under applicable federal and state law or pursuant to La. R.S. 24:31.5(C), and either:

- Receives at least sixty (60) percent of the total compensation available to employ the legislative assistant if the legislator Employer employs only one legislative assistant; or
- Is the primary legislative assistant as defined in La. R.S. 24:31.5(C) when a legislator Employer employs more than one legislative assistant.

2. Documented Dependent Coverage - Eligibility

- a. Documented Dependent of an Eligible Employee will be eligible for Dependent coverage on the latest of the following dates:
 - (1) The date the Employee becomes eligible.
 - (2) The Date Acquired for Employee's Dependents.
- b. Effective Dates of Coverage – Application for coverage must be made within thirty (30) days of eligibility for coverage. Coverage will be effective on the Date Acquired.
- c. No one may be enrolled simultaneously as an Employee and as a Dependent under the Plan, nor may a Dependent be covered by more than one Employee or retired Employee.

3. HIPAA Special Enrollment Events

Certain Eligible Persons may enroll in the Plan if they experience a HIPAA Special Enrollment Event as provided by federal law. HIPAA Special Enrollment Events include but are not limited to birth, adoption, placement for adoption, marriage, eligibility for premium assistance subsidy under Medicaid or State Children's Health Insurance Program (SCHIP) coverage, loss of other health coverage through

divorce, legal separation, or annulment, and loss of eligibility based on termination of Medicaid or SCHIP coverage. Application to the Plan Administrator must be made within thirty (30) days of the HIPAA special enrollment event unless a longer period is provided by federal law or by OGB.

4. Other Special Enrollment or Disenrollment Events

Employees may also change coverage outside of Annual Enrollment if they or an applicable eligible Dependent experience an OGB Plan-Recognized Qualified Life Event that allows for a specific change in coverage and make timely application to the Plan Administrator for such. The OGB Plan-Recognized Qualified Life Events are subject to change at any time and can be found at <http://info.groupbenefits.org/gle/>.

B. Continued Coverage

1. Leave of Absence

a. Leave of Absence without Pay, Employer Contributions to Premiums

- (1) A participating Employee who is granted leave of absence without pay due to a service-related injury may continue coverage and the Participant Employer shall continue to pay its portion of health plan premiums for up to twelve (12) months if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.
- (2) A participating Employee who suffers a service-related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the Participant Employer shall continue to pay its portion of the premium until the Employee becomes gainfully employed or is placed on state disability retirement.
- (3) A participating Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the Participant Employer shall continue to pay its portion of premiums if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

b. Leave of Absence Without Pay - No Employer Contributions to Premiums

An Employee granted leave of absence without pay for reasons other than those stated above in B.1., may continue to participate in an OGB Plan for a period up to twelve (12) months upon the Employee's payment of the full premiums due.

THE PARTICIPANT EMPLOYER AND THE EMPLOYEE MUST NOTIFY THE PLAN ADMINISTRATOR WITHIN THIRTY (30) DAYS OF THE EFFECTIVE DATE OF THE LEAVE OF ABSENCE.

2. Disability

- a. Employees who have been granted a waiver of premium for Basic or Supplemental Life Insurance prior to July 1, 1984, may continue health coverage for the duration of the waiver if the Employee pays the total contribution to the Participant Employer. Disability waivers were discontinued effective July 1, 1984.
- b. If a Participant Employer withdraws from the Plan, health and life coverage for all Covered Persons will terminate on the effective date of withdrawal.

3. Surviving Dependents/Spouse

- a. Benefits under the Plan for covered Dependents of a deceased covered Employee will terminate on the last day of the month in which the Employee's death occurred unless the surviving covered Dependents elect to continue coverage.
 - (1) The surviving Spouse of an Employee may continue coverage unless or until the surviving Spouse is or becomes eligible for coverage in a Group health plan other than Medicare.
 - (2) The surviving Dependent Child of an Employee may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a Group health plan other than Medicare or until end of the month of the attainment of the termination age for that specific Dependent Child, whichever occurs first.
 - (3) Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits.
 - (4) Coverage provided by the Civilian Health and Medical Program for the Uniform Services (CHAMPUS/TRICARE) or a successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving Spouse or a Dependent Child.
- b. A surviving Spouse or Dependent cannot add new Dependents to continued coverage other than a Child of the deceased Employee born after the Employee's death.
- c. Participant Employer/Dependent Responsibilities
 - (1) The Participant Employer and/or surviving covered Dependent shall notify the Plan Administrator within thirty (30) days of the death of the Employee.
 - (2) The Plan Administrator will notify the surviving Dependents of their right to continue coverage.
 - (3) Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of notification, and premium payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.
 - (4) Coverage for the surviving Spouse under this section will continue until the earliest of the following:
 - (i) Failure to pay the applicable premiums, contributions and surcharges timely.
 - (ii) Eligibility of the surviving Spouse under a Group health plan other than Medicare.
 - (5) Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:
 - (i) Failure to pay the applicable premiums, contributions and surcharges timely.
 - (ii) Eligibility of the surviving Dependent Child for coverage under any Group health plan other than Medicare; or
 - (iii) The end of the month of the attainment of the termination age for that specific Dependent Child.
- d. The provisions of paragraphs 3.a. through 3.c. above are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee.

Continued coverage for surviving Dependents that made such election before July 1, 1999, shall be governed by the rules in effect at the time of the election.

4. Over-Age Dependents

If a Dependent Child is incapable (and became incapable prior to attainment of age twenty-six (26)) of self-sustaining employment, by reason of physical or mental disability, the coverage for the Dependent Child may be continued for the duration of incapacity.

- a. No earlier than six (6) months prior to the Dependent Child reaching age twenty-six (26), an application for continued coverage must be filed with the Plan Administrator on a form designated by the Plan Administrator, with current medical information from the Dependent Child's attending Physician along with the Child's attending Physician's attestation of the Child's incapacity to perform self-sustaining employment, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.
- b. After the initial approval, the Plan Administrator may require the submission of additional medical or other supporting documentation substantiating the continuance of the disability, but not more frequently than annually, as a precondition to continued coverage.

5. Military Leave

Employees of the National Guard or in the United States military reserves who are called to active military duty and their covered eligible Dependents will have access to continued coverage under OGB's health and life plans subject to submittal of appropriate documentation to OGB.

- a. Health Plan Participation - When an Employee is called to active military duty, the Employee and his/her covered eligible Dependents may:
 - (1) continue participation in the health plan during the period of active military service, in which case the Participant Employer may continue to pay its portion of premiums; or
 - (2) cancel participation in the health plan during the period of active military service, in which case the Employee may apply for reinstatement of OGB coverage within thirty (30) days of:
 - (i) the date of the Employee's re-employment with a Participant Employer; or
 - (ii) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Employees who elect this option and timely apply for reinstatement of OGB coverage, the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851. (E) and the corresponding rules promulgated by OGB.

C. COBRA

1. Employees

- a. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.
- b. The Participant Employer shall notify the Plan Administrator within thirty (30) days of the date coverage would have terminated because of any of the foregoing events. OGB's third-party COBRA vendor ("COBRA Administrator") will notify the Employee within fourteen (14) days of his right to continue coverage.

- c. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification, and premium payment must be made to the COBRA Administrator within forty-five (45) days of the date the Employee elects continued coverage. Continued Coverage will be retroactive to the date it would have otherwise terminated.
- d. Coverage under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely;
 - (2) Eighteen (18) months from the date coverage would have otherwise terminated;
 - (3) Entitlement to Medicare;
 - (4) Coverage under a Group health plan; or
 - (5) The Employer ceases to provide any Group health plan for its Employees.
- e. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered Spouse and/or covered Dependent Children may elect to continue coverage at his/their own expense. The elected coverage will be subject to the above-stated notification and termination provisions.

2. Surviving Dependents

- a. Coverage under this Plan for covered surviving Dependents of an Employee will terminate on the last day of the month in which the Employee's death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.
- b. The Participant Employer or surviving covered Dependents shall notify the Plan Administrator within thirty (30) days of the death of the Employee. The COBRA Administrator will notify the surviving Dependents of their right to continue coverage within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification.
- c. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for the surviving Dependents under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely.
 - (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group health plan; or
 - (5) The Employer ceases to provide any Group health plan for its Employees.

3. Ex-Spouse/Ex-Stepchildren – Divorce, Annulment, Legal Separation or Death
 - a. Coverage under this Plan for an Employee's Spouse (and any stepchildren enrolled on the Plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment, or legal separation from the Employee, unless the covered ex-Spouse elects to continue coverage at his/her own expense.
 - b. Coverage under this Plan for an Employee's stepchild will terminate on the last day of the month of the death of the Employee's Spouse who is the stepchild's parent.
 - c. The Employee or the ex-spouse/ex-stepchild shall notify the Plan Administrator of the divorce, annulment, legal separation or death within sixty (60) days from the date of the divorce, annulment, legal separation or death. The COBRA Administrator will notify the ex-Spouse (and any ex-stepchildren of the Employee who were enrolled on the Plan) within fourteen (14) days of his/her/their right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the election notification.
 - d. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
 - e. Coverage for the ex-Spouse (and any ex-stepchildren of the Employee who were enrolled on the Plan) under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely.
 - (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group health plan; or
 - (5) The Employer ceases to provide any Group health plan for its Employees.
4. Dependent Children
 - a. Coverage under this plan for a covered Dependent Child will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent Child elects to continue coverage at his own expense.
 - b. The Dependent Child shall notify the Plan Administrator of his loss of eligibility for coverage within sixty (60) days of the date coverage would have terminated. The COBRA Administrator will notify the Dependent Child within fourteen (14) days of his/her right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of receipt of the election notification.
 - c. Payment of premiums, contributions and surcharges must be made to the COBRA Administrator within forty-five (45) days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

- d. Coverage for a Dependent Child under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely.;
 - (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group health plan; or
 - (5) The Employer ceases to provide any Group health plan for its Employees.

5. Dependents of COBRA Participants

- a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage, the covered Spouse or a covered Dependent Child becomes ineligible for coverage due to:
 - (1) Death of the Employee.
 - (2) Divorce, Annulment, or Legal Separation from the Employee, or
 - (3) A Dependent Child no longer meets the definition of an eligible covered Dependent, then, the Spouse and/or Dependent Child may elect to continue COBRA coverage at his/her own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.
- b. The Spouse and/or the Dependent Child shall notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.
- c. Monthly payments to the COBRA Administrator for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for the Spouse or Dependent Child under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely.
 - (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group Health Plan; or
 - (5) The Employer ceases to provide any Group health plan for its Employees.

6. Disability COBRA

- a. If a Plan Participant is determined by the Social Security Administration or by the COBRA Administrator staff (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient quarters of employment) to have been totally disabled on the date the Plan Participant became eligible for continued coverage or within the initial eighteen (18) months of continued coverage, coverage under this Plan may be extended at his own expense up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated.

- b. To qualify for disability COBRA, the Plan Participant must:
- (1) Submit a copy of his/her Social Security Administration's disability determination to the COBRA Administrator before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:
 - (i) The date of issuance of the Social Security Administration's disability determination; and
 - (ii) The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination or reduction of hours.
 - (2) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of employment, submit proof of total disability to the COBRA Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the COBRA Administrator will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.
- c. For purposes of eligibility for extended continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of twelve (12) months.
- To meet this definition, one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.
- d. Monthly payments for each month of extended disability COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- e. Coverage under this section will continue until the earliest of the following:
- (1) Failure to pay the applicable premiums, contributions and surcharges timely.
 - (2) Twenty-nine (29) months from the date coverage would have otherwise terminated.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group health plan.
 - (5) The Employer ceases to provide any Group health plan for its Employees; or
 - (6) Thirty (30) days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Plan Administrator and the COBRA Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the COBRA Administrator determines that the covered person is no longer disabled.

7. Medicare COBRA

- a. If an Employee becomes entitled to Medicare less than eighteen (18) months before the date the Employee's eligibility for Benefits under this Plan terminates, the period of continued coverage available for the Employee's covered Dependents will continue until the earliest of the following:
- (1) Failure to pay the applicable premiums, contributions and surcharges timely.

- (2) Thirty-six (36) months from the date of the Employee's Medicare entitlement.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group health plan; or
 - (5) The Employer ceases to provide any Group health plan for its Employees.
- b. Monthly payments to the COBRA Administrator for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

8. Miscellaneous Provisions

During the period of continuation of coverage, Benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Plan Participants.

D. Change of Classification

1. Adding or Deleting Dependents

When a Dependent is added to the Employee's coverage as a result of a HIPAA Special Enrollment Event or deleted from the Employee's coverage consistent with a change in the Dependent's status, application made by an active Employee shall be provided to the Employee's Human Resources liaison. Application is required to be made within thirty (30) days of the HIPAA Special Enrollment Event or change in status unless otherwise specified in this Plan document or unless a longer application period is required by federal or state law. When a Dependent is added to or deleted from coverage during an OGB-designated enrollment period, application is required to be made as directed by OGB for the designated enrollment period.

2. Change in Coverage

When the addition of a Dependent as a result of a HIPAA Special Enrollment Event results in a change in classification, the change in classification will be effective on the date of the HIPAA Special Enrollment Event.

3. Notification of Change

It is the Employee's responsibility to make application for any change in classification of coverage.

E. Contributions

The State of Louisiana may make a contribution toward the cost of the Plan, as determined by the Legislature.

F. Medical Child Support Orders

A Dependent Child shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). Application must be made within thirty (30) days of the receipt of the QMCSO or NMSN. Coverage will be effective the first of the month following OGB's receipt of timely application and all required supporting documentation. An Employee who is not currently enrolled in an OGB Plan may enroll to effect coverage for his or her Dependent(s) who are the subject of the QMCSO.

A QMCSO is a state court order or judgment, including approval of a settlement agreement that:

1. Provides for support of a covered Plan Participant's Dependent Child.

2. Provides for healthcare coverage for that Dependent Child.
3. Is made under state domestic relations law (including a community property law).
4. Relates to Benefits under the Plan; and
5. Is "qualified" in that it meets the technical requirements of applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the dependent Child of a non-custodial parent who is (or will become) a Covered Person by a domestic relations order that provides for healthcare coverage.

G. Termination of Coverage

Subject to continuation of coverage and COBRA rules, all benefits of a Plan Participant will terminate under this Plan on the earliest of the following dates:

1. The date the Plan terminates.
2. The date the Participant Employer terminates or withdraws from the Plan.
3. The date contribution is due if the Participant Employer fails to pay the required contribution.
4. The date contribution is due if the Plan Participant fails to make any contribution which is required for the continuation of coverage.
5. The last day of the month of the Plan Participant's death.
6. The last day of the month in which the Plan Participant ceases to be eligible as a Plan Participant.

ARTICLE IV.

BENEFITS

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

All Eligible Expenses are determined in accordance with Plan Limitations and Exclusions.

A. Benefit Categories

1. If this Benefit Plan includes more than one (1) Plan Participant, the Individual Deductible Amount is not applicable. The Family Deductible Amount applies.
2. If this Benefit Plan includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies.
3. Network and Non-Network Benefit categories may each carry separate Deductibles and Out-of-Pocket Amounts, as shown on the Schedule of Benefits.
 - a. Network Benefits (In-Network): Benefits for medical care received from a Network Provider. When a Plan Participant receives care from a Network Provider, he will receive the highest level of Benefits on this Plan.
 - b. Non-Network Benefits (Out-of-Network): Benefits for medical care received from a Provider who is not contracted with the Claims Administrator in the PPO Network. When a Plan Participant receives care from a Non-Network Provider, the Plan Participant, will receive a lower level of Benefits on this Plan.

B. Deductible Amount

1. Subject to the Deductible Amounts shown on the Schedule of Benefits, the maximum limitations hereinafter provided, and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in accordance with the Coinsurance percentage shown on the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period. The following Deductibles Amounts may apply to Benefits provided by this Plan. Deductible Amounts will accrue to the Out-of-Pocket Amount.
 - a. Individual Deductible Amount: The dollar amount, shown on the Schedule of Benefits, of Allowable charges for Covered Services, which a Plan Participant with Employee Only coverage must pay within a Benefit Period before the Plan starts paying Benefits.
 - b. Family Deductible Amount: The dollar amount, shown on the Schedule of Benefits, of Allowable charges for Covered Services, which must be paid by a family within a Benefit Period before the Plan starts paying Benefits. No Benefits are eligible for payment on any covered member of the family until the total Family Deductible Amount has been met. After the Family Deductible Amount is met, the Plan starts paying Benefits for all covered members of the family, for the remainder of the Benefit Period.
 - c. For the purposes of this Benefit Plan, "Family" includes all available classes of coverage except single Employee or Employee Only coverage.

C. Coinsurance

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 based on the Coinsurance shown on the

Schedule of Benefits toward Allowable charges for Covered Services. The actual payment to a Provider or payment to the Plan Participant satisfies the Plan Sponsor's obligation to provide Benefits under this Benefit Plan.

D. Out-of-Pocket Amount

1. Individual Out-of-Pocket Amount: The maximum amount, shown on the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amount and Coinsurance), which may be paid by a Plan Participant with Employee Only coverage, within a Benefit Period. After the Individual Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Covered Services, for the remainder of the Benefit Period.
2. Family Out-of-Pocket Amount: The maximum amount, shown on the Schedule of Benefits, of non-reimbursable expenses for Covered Services (including any applicable Deductible Amounts and Coinsurance), which may be paid by a family within a Benefit Period. If the Benefit Plan covers more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and the Per Member within a Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Covered Services, for all covered members of the family, for the remainder of the Benefit Period, whether each member has met the Per Member within a Family Out-of-Pocket Amount.
3. Per Member within a Family Out-of-Pocket Amount: The maximum dollar amount, shown on the Schedule of Benefits, of non-reimbursable expenses for Network Covered Services, which may be paid by one (1) family member within a Benefit Period. After the Per Member within a Family Out-of-Pocket Amount is met, the Plan will pay one hundred percent (100%) of the Allowable charge for Network Covered Services, for that family member, for the remainder of the Benefit Period. No family member may contribute more than the Per Member within a Family Out-of-Pocket Amount towards satisfaction of the Family Out-of-Pocket Amount.
4. The following accrue to the Out-of-Pocket Amount:
 - a. Deductible Amounts.
 - b. Coinsurance.
5. The following do not accrue to the Out-of-Pocket Amount:
 - a. any charges in excess of the Allowable Charge.
 - b. any penalties the Plan Participant or Provider must pay; and
 - c. any charges for non-covered health services.
 - d. any other amounts paid by the Plan Participant other than Deductibles and Coinsurance.
6. Eligible Expenses for services of a Network Provider that are applied to the Out-of-Pocket Amount for Network Providers will not apply toward the Out-of-Pocket Amount for Non-Network Providers.

Eligible Expenses for services of a Non-Network Provider that apply toward the Out-of-Pocket Amount for Non-Network Providers will not apply toward the Out-of-Pocket Amount for Network Providers.

When the Out-of-Pocket Amount, as shown above, has been satisfied, this Plan will pay 100% of the Allowable Charge toward Eligible Expenses for the remainder of the Plan Year.

E. Accumulator Transfers

If necessitated as a direct result of a HIPAA Special Enrollment Event or COBRA Qualifying Life Event, Plan Participants may transfer from one of the Group's self-insured Plans to another Group self-insured Plan with the same Claims Administrator. A Plan Participant's accumulators may be carried from the old Plan to the new Plan. Accumulators include, but are not limited to, Deductibles, Out-of-Pocket Amount, or Benefit Period Maximums.

ARTICLE V.

HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-Emergency, Emergency, Pregnancy Care, Mental Health and Substance Use Disorder Admissions) must be Authorized as outlined in Authorization of Services or Pregnancy Care Benefits. In addition, at regular intervals during the Inpatient stay, the Plan will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care. The Plan Participant must pay any Deductible Amount and any Coinsurance as shown on the Schedule of Benefits.

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit, for a critically ill Plan Participant 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 the Claims Administrator. A maximum number of days per Benefit Period may apply if shown on the Schedule of Benefits.
4. In a Residential Treatment Center for Plan Participants with a Mental Health or Substance Use Disorder.

B. Surgical Services (Inpatient and Outpatient)

1. Surgery

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.

2. Multiple Surgical Procedures

When Medically Necessary multiple procedures (concurrent, successive, or other multiple surgical procedures) are performed at the same surgical setting, Eligible Expenses will be paid as follows:

a. Primary Service

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

b. Secondary Service

The secondary service is a service performed in addition to the primary service, service as determined by the Claims Administrator. The Allowable Charge for the secondary service will be

based on a percentage of the Allowable Charge that would be applied had the secondary service been the primary service.

c. Incidental Service

- (1) An incidental service is one carried out at the same time as a primary service as determined by the Claims Administrator.
- (2) Covered incidental services are not reimbursed separately. The Allowable Charge for the primary service includes coverage for the incidental service. If the primary service is not covered, any incidental service will not be covered.

d. Unbundled Service

- (1) Unbundling occurs when two (2) or more service codes are used to describe a medical or surgical service performed when a single, more comprehensive service code exists that accurately describes the entire medical or surgical service performed. The unbundled services are considered included in the proper comprehensive service code as determined by the Claims Administrator.
- (2) The Allowable Charge of the comprehensive code includes the charge for the unbundled services. The Plan will provide Benefits according to the proper comprehensive service code, as determined by the Claims Administrator.

e. Mutually Exclusive Service

- (1) Mutually exclusive services are two (2) or more services that usually are not performed at the same operative session or encounter on the same patient on the same date of service. Mutually exclusive services may also include different service code descriptions for the same type of services in which the Physician should be submitting only one (1) of the codes. One or more of the duplicative services is not reimbursable as it should be reimbursed only one time.
- (2) The Allowable Charge includes all services performed at the same encounter. Any and all service 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.

C. Other Hospital Services (Inpatient and Outpatient)

Benefits are available for the following services, drugs, supplies, and devices, when performed, prescribed, or ordered by a Physician and Medically Necessary for the Treatment of a Plan Participant.

1. Hospital Care includes the medical services, supplies, treatments, drugs, and devices furnished by a hospital or Ambulatory Surgical Center.
2. Use of operating, delivery, recovery and treatment rooms and equipment.
3. Drugs and medicines including take-home Prescription Drugs.
4. Covered Services of a Physician.
5. Routine Nursing Services, i.e., "floor nursing" services provided by nurses employed by the hospital are considered as part of the room and board.
6. Diagnostic testing, including, but not limited to, laboratory services and Low-Tech Imaging.
7. Nuclear medicine and electroshock therapy.
8. Blood, blood derivatives, and blood processing, when not replaced.
9. Medical and Surgical supplies billed for treatment received in a Hospital or Ambulatory Surgical Center.
10. Intravenous injections, solutions, and related intravenous supplies.
11. Physical Therapy provided by a Hospital employee.
12. Psychological testing ordered by the attending Physician and performed by a Hospital employee.

D. Emergency Room

Benefits are available for Emergency Medical Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. If the Plan Participant receives treatment from a Non-Network facility and the Plan Participant's condition is an Emergency as defined in the Definitions Article of this Benefit Plan, Benefits will be paid at the Network level.

E. Pre-Admission Testing

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

ARTICLE VI.

MEDICAL AND SURGICAL BENEFITS

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

A. Surgical Services

1. Surgery
 - a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. 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 Benefit Payment is allowed toward charges for office visits on the same day as the Surgery.
2. Multiple Medical or Surgical Services - When Medically Necessary multiple services (concurrent, successive, or other multiple medical or surgical services) are performed at the same encounter, Eligible Expenses will be paid as follows:
 - a. Primary Service
 - (1) The primary or major service is determined by the Claims Administrator.
 - (2) Benefit Payment for the primary service will be based on the Allowable Charge.
 - b. Secondary Services

A secondary service is a service performed in addition to the primary service as determined by the Claims Administrator. The Allowable Charge for the secondary service will be based on a percentage of the Allowable Charge that would be applied had the secondary service been the primary service.
 - c. Incidental Service
 - (1) An incidental service is one carried out at the same time as a primary service as determined by the Claims Administrator.
 - (2) Covered incidental services are 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 service 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 Plan 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 are available for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. The Physician that provides a second or third opinion must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory to receive Benefits.

B. Inpatient Medical Services

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

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

C. Outpatient Medical Services and Surgical Services

1. Home, office, and other Outpatient visits for examination, diagnosis, and treatment of an illness or injury. Benefits for Outpatient medical services do not include separate payments for routine pre-operative and post-operative medical visits for Surgery or Pregnancy Care.
2. Consultation (as defined in this Benefit Plan).
3. Diagnostic Services.
4. Services of an Ambulatory Surgical Center.
5. Services of an Urgent Care Center.
6. Medically necessary/non-Investigational Prescription Drugs requiring parenteral administration in a Physician's Office are payable under this medical Benefit.
7. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician's office are payable under this medical Benefit.

ARTICLE VII

PRESCRIPTION DRUG BENEFITS

- A. Coverage is available for Prescription Drugs. The Prescription Drugs must be dispensed on or after the Plan Participant's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge and only those Prescription Drugs that the Claims Administrator determines are Medically Necessary will be covered.
- B. The Plan Participant can view the Claim Administrator's Blue Selections Rx Plan Participant Guide at www.bcbsla.com or request a copy by mail by calling the Claim Administrator's Pharmacy Benefit Manager at the telephone number indicated on the Plan Participant's ID card.
- C. Select diabetic supplies, including but not limited to, necessary continuous glucose monitors and associated supplies, insulin syringes and test strips are covered under the Prescription Drug Benefit.
- D. The Claims Administrator's Drug Utilization Management Program features a set of closely aligned programs that are designed to promote Plan Participant safety, appropriate and cost-effective use of medications, and monitor healthcare quality. Examples of these programs include:
 - 1. Prior Authorization – As part of the Prescription Drug Utilization Management program, Plan Participants and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing at www.bcbsla.com or by calling the customer service telephone number on the Plan Participant's ID card. If the Prescription Drug requires prior Authorization, the Plan Participant's Physician must call the medical Authorization telephone number on the Plan Participant's ID card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.
 - 2. Safety checks – Before the Plan Participant's prescription is filled, the Claims Administrator's Pharmacy Benefit Manager or the Claims Administrator performs quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g., refill prior to seventy-five (75%) day supply used).
 - 3. Quantity Per Dispensing Limits/Allowances – Prescription Drugs selected by the Claims Administrator are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity per Dispensing Limits/Allowances are based on the following:
 - (a) the manufacturer's recommended dosage and duration of therapy.
 - (b) common usage for episodic or intermittent treatment.
 - (c) FDA-approved recommendations and/or clinical studies; or
 - (d) as determined by the Plan.
 - 4. Step Therapy – Certain drugs and/or drug classes are subject to Step Therapy. In some cases, the Plan Participant may be required to first try one or more Prescription Drugs to treat a medical condition before the Plan will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Plan Participant's medical condition, the Plan Participant's Physician may be required to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Plan will cover a prescription written for Drug B. However, if Your physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B Drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the drug.

5. Step Therapy Overrides – Your Provider prescribing the Prescription Drug may request a Step Therapy override.
 - a. Step Therapy overrides are provided for stage-four advanced, metastatic cancer or associated conditions when certain criteria exist; step therapy overrides are also provided for other conditions when certain criteria are met.
 - b. When a Step Therapy Override request is submitted, We will respond to the request within seventy-two hours unless exigent circumstances exist, in which case We will respond to the request within twenty-four hours. If We do not make the determination timely, then the override request is considered approved.
 - c. If a Step Therapy Override request is denied, an Appeal can be submitted.
- E. Some pharmacies have contracted with the Claims Administrator or with the Claims Administrator's Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." Benefits are based on the Allowable Charge as determined by the Claims Administrator. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies must be based on the amount the Claims Administrator pays its Pharmacy Benefit Manager or the amount the Claims Administrator negotiates with the Plan. Those applicable amounts are used by the Claims Administrator to base the Plan's payment for a Plan Participant's Covered Prescription Drugs and the amount that a Plan Participant must pay for covered Prescription Drugs.

To obtain contact information for the contracted specialty pharmacy, the Plan Participant should contact the Claims Administrator or the Claims Administrator's Pharmacy Benefit Manager at the telephone number indicated on His ID card.

- F. When a Plan Participant purchases covered Prescription Drugs from a pharmacy that has not contracted with the Claims Administrator or with the Claims Administrator's Pharmacy Benefit Manager or the Plan Participant has filed a paper Claim with the Claims Administrator or its Pharmacy Benefit Manager, the Allowable Charge is the amount the Claims Administrator pays its Pharmacy Benefit Manager or the amount the Claims Administrator negotiates with the Plan.
- G. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Plan Participant should submit Claims on the Claims Administrator's Prescription Drug Claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Plan Participant should contact the Claims Administrator or the Claims Administrator's Pharmacy Benefit Manager at the telephone number indicated his ID card.
- H. As part of the Claims Administrator's administration of Prescription Drug Benefits, the Claims Administrator may disclose information about the Plan Participant's Prescription Drug utilization, including the names of the Plan Participant's prescribing Physicians, to any treating Physicians or dispensing pharmacies.
- I. The Plan shall receive one hundred percent (100%) of savings realized by the Claims Administrator under their cost containment programs that are attributable to Claims under the Plan, through billing of actual payments for Claims made under these programs.
- J. This Benefit Plan uses an open Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under the Plan. With an open formulary, new Prescription Drugs are automatically included to the list when drug manufacturers release these new drugs for sale. Placement of Prescription Drugs on a drug tier may be based on a drug's quality, safety, clinical efficacy, available alternatives, and cost. The Claims Administrator reviews the Prescription Drug Formulary at least once per year.

Plan Participants can review and print Formulary information and the Claims Administrator's Blue Selections RX Member Guide from the website, www.bcbsla.com. A copy sent by mail may be requested by calling the Pharmacy Benefit Manager at the telephone number indicated on the Plan Participant's ID card. Plan Participant's may also contact the Claims Administrator to ask whether a specific drug is included in the Prescription Drug Formulary for this Benefit Plan. If a Prescription Drug is on the Formulary, there is no guarantee that the Plan Participant's Physician or other authorized prescriber will prescribe the drug for a particular medical condition. A written Appeal may be filed if a Prescription Drug is not included in the Formulary and the Plan Participant's Physician, or authorized prescriber has determined that the drug is Medically Necessary. Instructions for filing an Appeal are found in the Complaint, Grievance and Appeal Procedures Article of this Benefit Plan.

K. Prescription Drug Benefits

After the Deductible Amount has been met, Prescription Drugs dispensed at retail or through the mail will be provided at the applicable Coinsurance shown in the Schedule of Benefits.

The Plan Participant should present his ID card to the pharmacist when purchasing covered Prescription Drugs at a participating pharmacy.

1. The participating pharmacy may collect one hundred percent (100%) of the discounted cost of the drug at the point of sale if the Plan Participant has not met his Deductible. If the Plan Participant has met his Deductible, he will pay the applicable Coinsurance percentage shown in the Schedule of Benefits.
2. The participating pharmacy will electronically submit the Claim for the Plan Participant. The Deductible Amount and Coinsurance will be applied, and any applicable reimbursement will be sent to the Plan Participant.
3. Prescription Drug Coinsurance are based on the following tier classifications shown in the Schedule of Benefits. Tier placement is based on the Claims Administrator's evaluation of a particular medication's clinical efficiency, safety, cost, and pharmacoeconomic factors.
 1. Tier 1 - A Prescription Drug that is a Generic or a low-cost Brand-Name Drug.
 2. Tier 2 - A Prescription Drug that is a Preferred Brand-Name Drug.
 3. Tier 3 - A Prescription Drug that is a Non-Preferred Brand-Name Drug or a Generic Drug that may have a therapeutic alternative as a Tier 1 or Tier 2 drug. Covered compounded drugs are included in this Tier.
 4. Tier 4 - Specialty Drugs

L. PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.
5. Prescription Drugs that the Claims Administrator determines are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered on the Schedule of Benefits:
 - a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), enhancing athletic performance, hair loss or restoration (e.g.,

Propecia®, Rogaine®), except for Prescription Drugs approved by Claims Administrator to treat alopecia areata or alopecia universalis, effects of aging on the skin, obesity, weight loss, weight management, or weight maintenance (e.g., Contrave®, Qsymia®, Saxenda®, Wegovy™)

- b. any medication not proven effective in general medical practice.
- c. Investigational drugs and drugs used other than for the FDA approved indication along with all Medically Necessary services associated with the administration of the drug, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals or the drug is expected to provide a similar clinical outcome for the covered indication as those included in nationally accepted standards of medical practice as determined by the Claims Administrator;
- d. fertility drugs.
- e. nutritional or dietary supplements, or herbal supplements and treatments, except those required to be covered by the United States Preventive Services Task Force preventive services recommendations.
- f. prescription vitamins not listed as covered in the Prescription Drug Formulary (including but not limited to Enlyte).
- g. drugs that can be lawfully obtained without a Physician's order, or that do not require a prescription, including over-the-counter (OTC) drugs, except those required to be covered by law.
- h. selected Prescription Drugs for which there is an OTC-equivalent or for which a similar alternative exists as an OTC medication.
- i. Prescription Drug products that include or are packaged with a non-Prescription Drug product;
- j. Prescription Drug compounding kits.
- k. selected Prescription Drug products that are packaged in a way that contains more than one Prescription Drug.
- l. selected Prescription Drug products that contain more than one (1) active ingredient (sometimes called *combination drugs*).
- m. Prescription Drug products that contain marijuana, including medical marijuana.
- n. Over the counter COVID-19 test kits (at home COVID tests) are excluded through medical benefit. Safe harbor not applicable. Claims will only be processed through the group's carved out Pharmacy Benefit Manager.
- o. Selected Prescription Drug products with multiple therapeutic alternatives which may be available in a greater or lesser strength or different dosages form (e.g., capsule, liquid, suspension, extended release, tamper resistant).
- p. refills in excess of the number specified by the Physician or the dispensing limitation described in this Benefit Plan, or a refill prior to seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription.
- q. compounded drugs that exhibit any of the following characteristics: (1) are similar to a commercially available product; (2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval; (3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being

- administered topically); (4) compounded drugs that contain drug products or components of such drug products that have been withdrawn or removed from the market for reasons of safety; or (5) compounded prescriptions whose only ingredients do not require a prescription.
- r. drugs for non-covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®).
 - s. Prescription Drugs filled prior to the Plan Participant's Effective Date or after a Plan Participant's coverage ends.
 - t. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage.
 - u. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®).
 - v. medication, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or the relevant state, or that are dispensed or used in an illegal manner.
 - w. growth hormone therapy, except as specified in the Schedule of Benefits.
 - x. Prescription Drugs for and/or treatment of idiopathic short stature; or
 - y. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Plan Participant misrepresentation to that prescriber. Limitation may include but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy.
 - z. topically applied prescription drug preparations that are approved by the FDA as medical devices.
 - aa. Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider unless the Provider is contracted with the Pharmacy Benefit Manager.
 - bb. Covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include but are not limited to intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration as determined by BCBSLA are covered under the medical benefit and excluded under the pharmacy benefit.
 - cc. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Plan Participant's Coinsurance and the Plan's financial responsibility. The Plan will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Plan Participant's Copayment, in which case, the Plan Participant must pay the Prescription Drug cost and sales tax.

ARTICLE VIII.

PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to a Plan Participant upon the effective date required for coverage. If a Plan Participant receives for Preventive or Wellness Care services from a Network or Non-Network Provider, the services will be paid at one hundred 100% percent of the Allowable Charge. The Deductible Amount will not apply to covered services received for Preventive or Wellness Care. Preventive or Wellness Care services may be subject to other limitations shown on the Schedule of Benefits.

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

1. Routine visits to Network Providers for obstetrical or gynecological care. Additional visits to a Provider for obstetrical or gynecological care for services other than covered Prevention or Wellness Care may be subject to the Deductible Amount or Coinsurance percentage shown on the Schedule of Benefits.
2. One (1) routine Pap smear per Benefit Period.
3. One (1) mammography examination, including breast ultrasound per Benefit Period. For Plan Participants ages 40-49, a mammography examination, including breast ultrasound may be conducted more frequently if recommended by a Physician. Any additional mammography examinations recommended by the Plan Participant's Physician may be subject to Deductible Amounts and Coinsurance shown on the Schedule of Benefits. A breast ultrasound may be completed alone or in conjunction with a mammogram.
4. All film mammograms, 3-D mammograms (digital breast tomosynthesis), and breast ultrasounds are covered at no cost when obtained from a Network Provider. Mammograms obtained from a Non-Network Provider will be subject to Coinsurance as shown on the Schedule of Benefits.
5. When required by applicable law, Breast MRIs will be covered under this Preventive or Wellness Care Benefit, but not at one hundred percent (100%). The Deductible Amount will not apply for Breast MRIs. Benefits will be subject to Coinsurance shown on the Schedule of Benefits for High-Tech Imaging Services. Any MRIs that are not covered under this Preventive or Wellness Care Benefit may be covered under standard contract Benefits for High-Tech Imaging Services when Medically Necessary.

B. Physical Examinations and Testing (Benefit Period Deductible does not apply)

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

High-Tech Imaging Services such as an MRI, MRA, CT scan, PET scan, and nuclear cardiology are not covered under this Preventive or Wellness Care Benefit. These High-Tech Imaging Services are subject to Deductible Amount and Coinsurance percentage when the tests are Medically Necessary.

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

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

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

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

5. Bone Mass Measurement – scientifically proven tests for the diagnosis and treatment of osteoporosis if a Plan Participant is:
 - a. an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment.
 - b. an individual receiving long-term steroid therapy; or
 - c. an individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.

One (1) osteoporosis screening, per Benefit Period, is available at no cost to the Plan Participant, for women age 65 and older, or one (1) every 2 years for younger postmenopausal women at risk.,

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

C. Immunizations (Benefit Period Deductible does not apply)

Immunizations, including, but not limited to, seasonal flu immunizations, as recommended by the Plan Participant's Physician or required by law.

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

In addition to the Preventive or Wellness (Routine) Care, the Plan will cover 100% of the Allowable Charges for 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. To check the current list of recommended Preventive or Wellness Care services required by PPACA, visit the United States Department of Health and Human Services' website at: <https://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 [cbbsla.com/birthcontrol](https://www.cbbsla.com/birthcontrol). This exception process is only applicable to plans which cover contraceptive services.

E. New Recommended Preventive or Wellness Care Services

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

ARTICLE IX. MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- A. Treatment of Mental Disorders are available. Covered services will be only those which are for treatment rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for the treatment of Mental Disorders do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and employment counseling. Coverage for Mental Health includes services delivered through the Psychiatric Collaborative Care Model when used to treat a behavioral health diagnosis approved by Claims Administrator.
- B. 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. Coverage for substance use disorders includes services delivered through the Psychiatric Collaborative Care Model when used to treat a behavioral health diagnosis approved by the Claims Administrator.

Refer to the Schedule of Benefits for more information on Mental Health and Substance Use Disorder Benefits.

ARTICLE X. ORAL SURGERY AND DENTAL SERVICES

A. Surgical Services

Benefits are available for the following oral and maxillofacial surgeries:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination.
2. External incision and drainage of cellulitis.
3. Incision of accessory sinuses, salivary glands or ducts.
4. Frenectomy (the cutting of the tissue in the midline of the tongue).
5. Reduction of fractures and dislocations of the jaw.

The highest level of Benefits is available when services are performed by a Network Provider, or by a Provider in Blue Cross and Blue Shield of Louisiana's dental network. Access the dental network online at www.bcbsla.com/ogb or call the Customer Service telephone number on the Your ID card for a copy of the directory.

B. Dental Services

1. Dental exams and x-rays needed to diagnose impacted teeth are NOT covered. Once diagnosed, removal and any pre-op and post-op care associated with the removal of the impacted teeth are covered.
2. 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. Services must begin within ninety (90) days of the accidental injury and be completed within twenty-four (24) months after the date of injury.
3. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required to restore bodily function for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth.

The highest level of Benefits is available when services are performed by a Network Provider, or by a Provider in Blue Cross and Blue Shield of Louisiana's dental network. Access the dental network online at www.bcbsla.com/ogb or call the Customer Service telephone number on the Your ID card for a copy of the directory.

C. Anesthesia Services

1. Anesthesia for the above services or procedures when rendered by an oral surgeon.
2. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
3. Anesthesia when rendered in a Hospital or Outpatient facility setting and for associated Hospital charges when a Plan Participant's mental or physical condition requires dental treatment to be rendered in a Hospital or Outpatient facility setting.

ARTICLE XI. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

The Claims Administrator's 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 Claims Administrator must receive adequate information to verify coverage, determine that the procedure is Medical Necessary, and approve the site 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 Transplants

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) **for the specific organ or transplant**, or a Blue Cross and Blue Shield of Louisiana PPO Network Provider facility, unless otherwise approved by the Claims Administrator and the Plan Administrator in writing.

To locate a BDCT or BCBSLA Network Provider facility, Plan Participants should contact Our customer service department at the number listed on the ID card.

2. The Organ, Tissue and Bone Marrow Transplant Benefits are shown in the Schedule of Benefits, and are not covered when services are rendered by a Non-Network Provider.
3. Benefits for organ, tissue and bone marrow transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).
4. Benefits as specified in this section will be provided for treatment and care as a result of, or directly related to, the following transplant procedures.

a. Solid human organ transplants 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 the Medical and Surgical Benefits Article and do not require prior Authorization. Evaluation for Tissue Transplant is not required. If an Inpatient Admission is required, it is subject to the Article on Care Management.

The following tissue transplants are covered:

- (1) blood transfusions.
- (2) autologous parathyroid transplants.
- (3) corneal transplants.
- (4) bone and cartilage grafting.
- (5) skin grafting.
- (6) autologous islet cell transplants; and
- (7) other tissue transplant procedures which 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) Peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.
- (3) 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 XII.

PREGNANCY CARE AND NEWBORN CARE BENEFITS

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

Benefits for treatment of ectopic pregnancies and spontaneous abortions are available for all covered Plan Participants under Article V and Article VI of this Benefit Plan the same as any other Covered Service, and are not subject to this Article.

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. Authorization must be requested within twenty-four (24) hours of the initial exceedance of the 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.

To use certain Providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Authorization. For information on Authorization, contact the Claims Administrator.

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.

For Non-Network Benefits, if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described authorization for continued stay must be obtained from the Claims Administrator. If authorization is not obtained, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

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 prenatal and postnatal care.
- d. Medically Necessary abortions required in order to save the life of the mother.

2. Doula Services

Maternity support services are available when provided by a registered Doula to pregnant and birthing women and their families before, during, and after childbirth. Benefits are limited to \$1500 per pregnancy when services are rendered by a Network Doula and are subject to any applicable Copayment, Deductible Amount and Coinsurance. Services rendered by a Non-Network Doula are not covered.

3. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for a well newborn is included in the mother's Eligible Expenses 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 Plan is the father.
4. 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.

5. The Family Deductible Amount, as shown in the Schedule of Benefits, applies to all charges when a newborn is added to a Benefit Plan of a Plan Participant holding Employee Only coverage. This amount must be met prior to any Benefits being paid. In addition, coverage for the newborn will be pursuant to the provisions set forth in the Schedule of Eligibility Article of this Benefit Plan.

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

1. Medical and Surgical services rendered by a Physician, for treatment of illness, prematurity, post maturity, or 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, prematurity, post maturity, and congenital condition of a newborn are covered. Charges for services for a well newborn, including the Hospital (nursery) charge should not be billed separately from the mother's hospital bill. As determined by Us, well newborn charges may be covered if the Plan Participant under this Benefit Plan is the father.
3. The Family Deductible Amount, as shown on the Schedule of Benefits, applies to all charges when a newborn is added to a Benefit Plan of a Plan Participant holding Employee Only coverage. This amount must be met prior to any Benefits being paid. In addition, coverage for the newborn will be pursuant to the provisions set forth in the Schedule of Eligibility Article of this Benefit Plan.

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

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

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

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

ARTICLE XIII.

REHABILITATIVE AND HABILITATIVE CARE BENEFITS

Rehabilitative and Habilitative Care Benefits will be available for services and devices provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, Pulmonary Therapy Hearing Therapy, Cognitive Therapy, Cardiac Rehabilitation Pulmonary Rehabilitation and/or Chiropractic Services.

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

An Inpatient Rehabilitation Admission must be Authorized prior to the Admission and must begin within seventy-two (72) hours following the discharge from an Inpatient Hospital Admission for the same or similar condition, unless otherwise approved by 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 for these services may be subject to any limitation or maximum Benefits if shown on the Schedule of Benefits.

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, as shown in the Schedule of Benefits, when performed by a Provider licensed and practicing within the scope of his license, including, but not limited to a licensed occupational therapist or a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist.
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.

B. Physical Therapy

1. Physical Therapy services are covered, as shown in the Schedule of Benefits, 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 in adults age sixty-five (65) years and older.
- (e) To an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate, after the physical therapist informs 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 shown on the Schedule of Benefits, 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 an audiologist. Speech Therapy is not covered when maintenance level of therapy is attained.
2. The therapy must be used to improve or restore speech/language deficits, speech/language development disorders, cognitive-communication, or swallowing function.
3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to receiving of services.

D. Hearing Therapy

Benefits are available under this Plan for hearing therapy.

E. Cognitive Therapy

Benefits are available under this Plan for cognitive therapy.

F. Pulmonary Therapy

Benefits are available for Pulmonary Rehabilitation Therapy services when rendered by a licensed therapy Provider under the direction of a Physician.

G. Chiropractic Services

1. Chiropractic Services are covered, as shown in the Schedule of Benefits, 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 XIV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. Acupuncture Benefits

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

B. Acute Detoxification

Benefits are available for the medical treatment of acute detoxification resulting from Substance Use Disorders.

C. Ambulance Service Benefits

1. Ground Ambulance Transport Services

a. Emergency Transport

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

- (1) for 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 a Newly Born Infant, to the nearest Hospital or neonatal special care unit for treatment of illnesses, injuries, congenital birth defects and Complications of premature birth which require that level of care; or
- (3) For the Temporarily Medically Disabled Mother of an ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.

b. Non-Emergency Transport

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

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

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

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

2. 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 available for or 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

Air Ambulance Service situations require prior Authorization from Blue Cross and Blue Shield of Louisiana / HMO Louisiana, Inc. If Authorization is not obtained prior to services being rendered, the services will not be covered.

If Authorized by Blue Cross and Blue Shield of Louisiana / HMO Louisiana, Inc. 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.

3. Ambulance Service Benefits will be provided as follows:

- a. If a Plan Participant pays a periodic fee to an ambulance membership organization with which Blue Cross and Blue Shield of Louisiana / HMO Louisiana, Inc. 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 Blue Cross and Blue Shield of Louisiana / HMO Louisiana, Inc. 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 Participant between parts of its own campus or when a hospital transports Plan Participant between facilities owned or affiliated with the same entity.

D. 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.

E. Autism Spectrum Disorders (ASD)

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

Autism Spectrum Disorder Benefits are subject to the Deductible Amount and Coinsurance that are applicable to the Benefits obtained. Example: A Plan Participant obtains speech therapy for treatment of ASD. The Plan Participant will pay the applicable Deductible Amount and Coinsurance shown in the Schedule of Benefits).

F. 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.

Deductible and/or Coinsurance amounts may be applicable.

G. 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.

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

1. Under the Women's Health and Cancer Rights Act, a Plan Participant who is receiving Benefits in connection with a mastectomy and elects breast reconstruction will also receive Benefits for the following Covered Services:
 - a. All stages of reconstruction of the breast on which the mastectomy has been performed.
 - 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 lymphedema.

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 Copayment Amount, Deductible Amount, and Coinsurance.

2. Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of 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 Copayment Amount, Deductible Amount and Coinsurance.

I. Cleft Lip and Cleft Palate Services

The following services for the treatment and correction of cleft lip and cleft palate are covered:

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

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

J. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other Life-Threatening Illness or condition. Coverage will be subject to any applicable terms, conditions and limitations that apply under this Benefit Plan, including Deductible Amounts, or Coinsurance shown on the Schedule of Benefits.
2. A "Qualified Individual" under this section means a Plan Participant that:
 - a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Illness 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 Illness 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) 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) 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. Investigational drugs or devices, items or services themselves, and/or
 - d. Services, treatment or supplies not otherwise covered under this Benefit Plan.

5. Treatments and associated protocol-related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:
 - a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other Life-Threatening Illness, or for the prevention or early detection of such diseases.
 - b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial.
 - c. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state, and which has a multiple project assurance contract approved by the office of protection from research risks.
 - d. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
 - e. There must be no clearly superior, non-Investigational approach.
 - f. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-Investigational alternative.
 - g. The patient has signed an institutional review board approved consent form.

K. 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, diabetic/nutritional counseling and for the equipment and necessary supplies for the training, if prescribed by the Plan Participant's treating Provider.
 - b. Evaluation and training programs for diabetes self-management is covered subject to the following:
 - (1) The program must be prescribed by the Plan Participant's treating Provider and provided by a licensed healthcare professional who certifies that the Plan Participant has successfully completed the training program.
 - (2) The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.
 - c. Benefits are not available for Diabetes Education and Training for Self-Management services rendered by a Non-Network Provider.

2. Diabetic Retinal Screening

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

L. Disposable Medical Equipment or Supplies

Blue Cross and Blue Shield of Louisiana provides Claim payment services for Disposable Medical Equipment and Supplies provided by a medical Provider only when Medically Necessary and subject to reasonable quantity limits as determined by the Claims Administrator.

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

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

1. Durable Medical Equipment

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

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

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

- (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge);
- (2) At the Claims Administrator's option, on behalf of the Plan Administrator, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, oxygen and oxygen equipment 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.
 - 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 deemed by Us to be Medically Necessary.
- (4) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.
- (5) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or replacement of equipment damaged due to neglect or misuse will not be covered. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Benefit Plan, will not be covered. Regardless of Medical Necessity, repair, adjustment or replacement of equipment subject to a recall within five (5) years after purchase or rental will not be covered. Regardless of Medical Necessity, repair adjustment, or replacement of equipment will not be covered when

provided under warranty.

c. Limitations 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) 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.
- (6) Regardless of Claims of Medical Necessary, 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. 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 are 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, Devices and Prosthetic Services of the Limbs (Non-Limb and Limb)

Benefits will be available for the purchase of Prosthetic Appliances, Devices and Prosthetic Services that the Claims Administrator Authorizes 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. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.
- d. Mastectomy bras, limited to 3 (three) per Plan Year.
- e. When Prosthetic Appliances or Devices are approved by Us, Benefits for standard appliances or devices will be provided toward any deluxe appliance or device.
 - (1) Deluxe 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 are deluxe features and functionalities of devices that are not approved by Us are not covered.
- f. 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 the Benefit payable, without financial or contractual penalty to the Provider of the appliance or device.
- g. 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).

N. Eyeglasses

Benefits are available, as shown in the Schedule of Benefits, for eyeglass frames and lenses, or contact lenses when purchased within six (6) months following cataract surgery.

O. Fertility Preservation Services

Medically Necessary standard fertility preservation services are covered for a Plan Participant receiving Medically Necessary treatment that will result in Iatrogenic Infertility.

Standard fertility preservation services include extraction, cryopreservation, and up to three (3) years of storage of oocytes and sperm. No benefits are available for Prescription Drugs whether offered as a pharmacy Benefit or medical Benefit as part of the standard fertility preservation services.

Benefits for fertility preservation services are subject to a lifetime maximum of \$10,000. If storage costs have been covered for three (3) years, no additional Benefits will be provided, even if the \$10,000 lifetime maximum has not been met. This Benefit is subject to payment of any applicable Copayment, Deductible Amount and Coinsurance which will apply to the \$10,000 lifetime maximum.

P. 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 CLAIMS ADMINISTRATOR PRIOR TO SERVICES BEING PERFORMED; AND (2) SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM CLAIMS ADMINISTRATOR TO PERFORM YOUR PROCEDURE.

Q. 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.

R. Hearing Benefits for Plan Participants age 17 and under

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

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

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

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

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

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

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

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

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

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

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

S. Home Health Care

1. Home Health Care provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered and may be limited as shown on the Schedule of Benefits.
2. Home Health Care services provided to a Plan Participant must be ordered by a Physician and provided by or supervised by a registered nurse in the home setting.
3. Benefits are available when Home Health Care services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is defined as skilled nursing, skilled teaching and skilled rehabilitation services when:
 - a. it is delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide safety of the patient.
 - b. it is ordered by a Physician.
 - c. it requires clinical training in order to be delivered safely and effectively.
 - d. it is not custodial.

T. Hospice Care Benefits

1. Hospice Care is covered when recommended by a Physician and may be limited if shown on the Schedule of Benefits.
2. Benefits are available for Hospice Care when provided by a licensed Hospice agency.

U. Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter or transliterator are covered at one-hundred percent (100%) of the allowable charge when the Plan Participant needs such services in connection with medical treatment or diagnostic Consultations performed by a Physician or Allied Health Professional, if the services are required because of the Plan Participant's hearing loss or Your failure to understand or otherwise communicate in spoken language. These services are not covered if rendered by a family member, or if the medical treatment or diagnostic Consultation is not covered.

V. 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.

W. Lymphedema Benefits

Treatment of lymphedema is covered when rendered or prescribed by a licensed Physician or received in a Hospital or other public or private facility authorized to provide lymphedema treatment. Coverage includes but is not limited to multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

X. Pain Management Programs

Benefits are available for Pain Rehabilitation Control and/or Therapy designed to develop an individual's ability to control or tolerate chronic pain.

Y. Permanent Sterilization Procedures and Contraceptive Devices

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

Z. Prescription Donor Human Breast Milk

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

AA. Prescription Drugs

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

BB. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage.

CC. 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. Care rendered by Telehealth Services is also available for chronic care management for Plan Participants with two or more chronic conditions, and for prolonged preventative services, when more time is needed with the Provider beyond the typical time allotted for the service.

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

Telehealth Services generally must be held in real time 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 relationship 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 a chronic and/or acute health condition. This method of Remote Patient Therapy services is limited to services and devices approved by Us.

In order to be covered, Remote Patient Therapy services must specifically be required for medical treatment decision 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 services 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 must be rendered by a 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 for non-HIPPA compliant encounters which do not provide a system of secure communication to safeguard protected health information.

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

DD. Treatment of the Foot

Benefits for a total of six (6) services, treatments, or procedures for cutting or removal of corns and calluses are covered. Benefits for a total of six (6) services, treatments, or procedures for nail trimming and/or debridement are also covered. Benefits are limited to for these services, treatments, or procedures per Benefit Period whether such services, treatments, or procedures are provided by Network Providers or Non-Network Providers. All other services, treatments, or procedures in excess of the limits are not covered. The Plan Participant must pay any applicable Deductible Amount, Copayments or Coinsurance.

EE. Urgent Care Center

An Urgent Care Center visit is covered as shown on the Schedule of Benefits.

FF. Vision Care

1. Non-routine Vision Care exams are subject to the Deductible and Coinsurance amounts, as shown on the Schedule of Benefits.
2. Benefits are available for eyeglass frames and one pair of eyeglass lenses, or one pair of contact lenses required as a result of cataract Surgery and purchased within six (6) months following the cataract Surgery. Expenses incurred for the eyeglass frames will be limited to a maximum benefit of fifty dollars (\$50.00).

ARTICLE XV.

CARE MANAGEMENT

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

1. Authorization and Selection of Provider

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

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

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

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

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

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

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

If the Admission or other Covered Services were Medically Necessary, Benefits will be provided based on the Network status of the Provider rendering the services, as follows.

a. Admissions

- (1) If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.
- (2) If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with the other Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges.

The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered.

The Plan Participant remains responsible for any applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.

- (3) If a Non-Network Provider fails to obtain a required Authorization, We will reduce the Coinsurance by the percentage shown on the Schedule of Benefits. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.

b. Outpatient Services, Including Other Covered Services and Supplies

- (1) If a Blue Cross Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.
- (2) If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable unless the procedure is deemed Medically Necessary. If the procedure is deemed Medically Necessary, the Plan Participant remains responsible for his applicable Deductible and Coinsurance. If the procedure is not deemed medically necessary, the Plan Participant is responsible for all charges incurred.
- (3) If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce the Coinsurance by the percentage shown in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization. The Plan Participant is responsible for all charges not covered and remains responsible for his Deductible and applicable Coinsurance.

3. Authorization of Admissions

a. Authorization of Elective Admissions

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

- (1) If a request for Authorization is denied the Admission is not covered and the Plan Participant must pay all charges incurred during the Admission for which Authorization was denied.

- (2) If Authorization is not requested prior to an Admission, We 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 Network status of the Provider.
- (3) Additional amounts for which the Plan Participant is responsible because Authorization of an Elective or non-Emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not accrue to the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

It is the Plan Participant's responsibility to ensure that the Physician or Hospital, or a representative thereof, notifies Our care management department of all Emergency Admissions to guarantee coverage. Within forty-eight (48) hours of the Emergency Admission, We must be notified regarding the nature and purpose of the Emergency Admission. The facility or Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the facility or Provider. We may waive or extend this time limitation if We determine that the Plan Participant is unable to timely notify or direct a representative to notify Us of the Emergency Admission. In the event the end of the notification period falls on a holiday or weekend, We must be notified on the next working day. The appropriate length of stay for the Emergency Admission will be determined by Us when the Hospital Inpatient setting is documented to be Medically Necessary.

- (1) If Authorization is denied by Us, the Admission will not be covered, and the Plan Participant must pay all charges incurred during the Admission.
- (2) If Authorization is not requested, We 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 Network status of the Provider.
- (3) Additional amounts for which the Plan Participant is responsible because Authorization of an Emergency Admission was denied or not requested are considered non-covered and will not accrue to the Out-of-Pocket Amount.

c. Concurrent Review

When We Authorize a Plan Participant's Inpatient stay, We will Authorize 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 the Physician or Hospital contacts Us to request Concurrent Review for Authorization of additional days. This request for continued hospitalization must be made on or before the Plan Participant's last Authorized day so We can review and respond to the request that day. If We Authorize the request, We will again Authorize a certain number of days, repeating this procedure until the Plan Participant is either discharged or the Plan Participant's continued stay request is denied. To request Concurrent Review for Authorization of additional days, the Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or facility.

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

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

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

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

Certain services, supplies, and Prescription Drugs require Our Authorization before a Plan Participant receives the services, supplies, or Prescription Drugs. The Authorizations list is shown on the Plan Participant's Schedule of Benefits. The Plan Participant is responsible for making sure the Provider obtains all required Authorizations for him before the services, supplies, or Prescription Drugs are received. We may need the Plan Participant's Provider to submit medical or clinical information about the Plan Participant's condition. To obtain prior Authorizations, the Plan Participant's Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider.

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

b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, We 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 Network status of the Provider.

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

5. Cancer Patient's Right to Prompt Coverage Act

The requirements set forth in La. R.S. 22:1016.12 through La. R.S. 22:1016.16, the Cancer Patient's Right to Prompt Coverage Act related to prior Authorization (as defined therein) and coverage of services for the diagnoses and treatment of cancer will be followed.

6. Utilization Review Standards Required by Louisiana Law

The requirements set forth in La. R.S. 22:1260.41 through La. R.S. 22:1260.48 related to utilization review, including to prior Authorization (as defined therein), will be followed.

B. Population Health – In Health: Blue Health

1. Qualification

The Plan Participant may qualify for Population Health 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 health coach is assigned. The Plan Participant, Physicians and caregivers may be included in all phases of the Population Health program. The Population health coach may also refer Plan Participants to community resources for further support and management.

2. Population Health Benefits

The Population Health program targets populations with one or more chronic health conditions. The current chronic health conditions identified by OGB are diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). OGB may supplement or amend the list of chronic health conditions covered under this program at any time.

Through the In Health: Blue Health Services program, the health coach 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 lifestyle modification, and improve adherence to their Physician prescribed treatment plan. OGB and Blue Cross and Blue Shield of Louisiana are dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant. The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.

The In Health: Blue Health Services program offers an incentive to Plan Participants on certain Prescription Drugs used to treat the chronic conditions listed above. The prescription incentive does not apply to any Prescription Drug not used to treat one of these five health conditions with which You have been diagnosed.

To remain eligible for the Plan program, Plan Participants must actively engage with a BCBSLA health coach on a specified time interval appropriate for management of their healthcare needs. If Plan Participants fail to engage with health coach on the determined timeframe, Plan Participants will not be eligible for prescription incentive to treat chronic conditions listed above. Plan Participants can disenroll by calling 1-800-363-9159 and request disenrollment from In Health: Blue Health Services program.

C. Case Management – In Health: Blue Touch

1. Case Management (CM) is the managed care available in cases of illness or injury where critical care is required and/or treatment of extended duration is anticipated. The Plan Participant may qualify for Case Management services 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.
2. Case Management may provide coverage for services that are not normally covered. To be eligible, the illness or injury must be a covered condition under the Plan, and Case Management must be approved prior to the rendering of services and/or treatment.
3. 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.
4. 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 Plan in accordance with its express terms.
5. 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. Benefits for services and/or treatment approved by the Case Management are subject to the Deductible, Coinsurance and Allowable Charge.
6. 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 program.
- 7. Mental Health and Substance Use Disorder treatments/conditions are not eligible for Case Management.
 - 8. The Claims Administrator must be the primary carrier at the time of enrollment in Case Management.
 - 9. The Plan Participant may not be confined in any type of nursing home setting at the time of enrollment in Case Management.

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. Case Management may provide coverage for services that are not normally covered. To be eligible, the illness or injury must be a covered condition under the Plan. 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. Benefits for services and/or treatment approved by the Case Management are subject to the Deductible, Coinsurance and Allowable Charge.
- 4. Alternative Benefits provided under this section are provided in lieu of the Benefits to which the Plan Participant is entitled under this Benefit Plan and apply toward the maximum Benefit limitations under this Benefit 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.
- 6. The Claims Administrator must be the primary carrier at the time of request for Alternative Benefits.

ARTICLE XVI.

LIMITATIONS AND EXCLUSIONS

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

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

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

Unless otherwise shown as covered in the Schedule of Benefits, REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits for the following are excluded:

A. GENERAL

1. Medical services, supplies, treatments, and Prescription Drugs provided without charge to the Covered Person or for which the Covered Person is not legally obligated to pay.
2. 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.
3. Diagnostic or treatment measures that are Investigational or not recognized as generally accepted medical practice.
4. 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.
5. Services and supplies for the treatment of and/or related to gender dysphoria.
6. Services rendered, prescribed, or otherwise provided by a Physician or other healthcare Provider who is the Plan Participant, related to the patient by blood, adoption or marriage or who resides at the same address.
7. Expenses for services rendered by a Physician or other healthcare Provider who is not licensed in the state where such services are rendered or in any facility not holding a valid license in the state and for the services rendered.
8. Facility fees for services rendered in a Physician's office or in any facility not approved by the federal Health Care Finance Administration for Medicare reimbursement.
9. Charges to obtain medical records or any other information needed and/or required to adjudicate a claim.
10. Charges greater than the global allowance for any laboratory, pathology or radiological procedure.
11. Any charges exceeding the Allowable Charge except as specifically agreed in writing by the Claims Administrator and the Plan Administrator.

12. Services, Surgery, supplies, treatment, or expenses:
 - a. other than those specifically listed as covered by this Benefit Plan or for which a Plan Participant has no obligation to pay, or for which no charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the State of Louisiana or any of its political subdivisions.
 - b. rendered or furnished before the Plan Participant's Effective Date or after Plan Participant's coverage terminates.
 - 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. 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.
13. Anesthesia by hypnosis, or charges for anesthesia for non-covered services, except as specifically provided in this Benefit Plan.
14. Acupuncture when used to provide treatment for a condition or service that is excluded from coverage under this Benefit Plan.
15. Telephone calls, video communication, text messaging, e-mail messaging, or 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 the Claims Administrator. Telehealth Services rendered by a Non-Network Provider is not covered.
16. 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.
17. 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.
18. Any incidental procedure, unbundled procedure or mutually exclusive procedure, except as described in this Benefit Plan.
19. Benefits for the following, unless otherwise determined by this Plan:
 - a. immunotherapy for recurrent abortion.
 - b. chemonucleolysis.
 - c. biliary lithotripsy.
 - d. home uterine activity monitoring.
 - e. sleep therapy.
 - f. light treatments for seasonal affective disorder (SAD).
 - g. immunotherapy for food allergy.
 - h. Prolotherapy.
 - i. hyperhidrosis Surgery.

- j. sensory integration therapy.
20. Services provided at a free-standing or Hospital based diagnostic facility without an order written by a Physician or other Provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other Provider:
- a. has not been actively involved in the Plan Participant's medical care prior to ordering the service, or
 - b. is not actively involved in the Plan Participant's care after the service is received.

This exclusion does not apply to mammography testing.

21. Travel or transportation expenses, even though prescribed by a Physician.
22. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
- a. Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
 - b. Related to judicial or administrative proceedings or orders.
 - c. Conducted for purposes of medical research.
 - d. Required to obtain or maintain a license of any type.
23. In the event that a Non-Network Provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
24. 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.
25. Repatriation of remains from an international location back to the United States is not covered. Private or commercial air or sea transportation is not covered. Plan Participants traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to Your home country and air/sea travel when ambulance is not required.
26. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
27. Any charge for services, supplies or equipment advertised by the Provider as free.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.

B. COSMETIC

- 1. Services, supplies, or treatment for cosmetic purposes, including piercing, cosmetic Surgery and any Complications of cosmetic Surgery, unless necessary for the immediate repair of a deformity caused by disease and/or injury that occurs while coverage is in force. No payment will be made for expenses incurred in connection with the treatment of any body part not affected by the disease and/or injury.
- 2. REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits are excluded for services, Surgery, supplies, treatment or expenses for 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. hair pieces, wigs, hair growth and/or hair implants.
 - d. breast enlargement, except for breast reconstructive services as specifically provided in this Benefit Plan.
 - e. breast reduction, except for breast reconstructive Surgical services as specifically provided in this Benefit Plan.
 - f. implantation of breast implants and services; except for breast reconstruction Surgical services specifically provided in this Benefit Plan.
 - g. diastasis recti.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
 4. REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits for fat or skin removal surgery or similar services are excluded.
 - a. Weight loss programs whether for medical reasons or under medical supervision.
 - b. Any Bariatric Surgery or;
 - c. Obesity or morbid regardless of Medical Necessity, except as required by law.
 5. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to prescription donor human breast milk as described in this Benefit Plan. This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.
 6. 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.
 7. REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits are excluded for palliative or cosmetic care of treatment of the foot; supportive devices of the foot; and treatment of flat feet, except for Medically Necessary Surgery.
 8. REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits are excluded for routine foot care. except certain treatment of the foot specifically provided for in the Other Covered Benefits Article of this Benefit Plan.
 9. Pharmacological regimens, nutritional procedures or treatments that are primarily for cosmetic purposes.
 10. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other skin abrasion procedures); and skin abrasion procedures performed as a treatment for acne.
 11. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
 12. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

13. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
14. Medical and surgical treatment of excessive sweating (hyperhidrosis).
15. Panniculectomy, abdominoplasty, thighplasty, brachioplasty and mastopexy.

C. COMFORT OR CONVENIENCE ITEMS

1. Maintenance therapy consisting of convalescent, skilled nursing, sanitarium, custodial care, assisted living facilities, or rest cures designed to assist in daily living activities, maintain present physical and/or mental condition, or provide a structured or safe environment.
2. Personal convenience items including, but not limited to, admit kits, bedside kits, telephone, television, guest meals, and beds, and charges for luxury accommodations in any hospital or allied health facility provided primarily for the patient's convenience which are not deemed Medically Necessary by the Claims Administrator.
3. Non-medical supplies such as air conditioners and/or filters, dehumidifiers, air purifiers, wigs or toupees, heating pads, cold devices, home enema equipment, rubber gloves, swimming pools, saunas, whirlpool baths, home pregnancy tests, lift chairs, exercise equipment, any other items not normally considered medical supplies.
4. Services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.).
5. 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.
6. Medical and Surgical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).
7. Alternative Treatments including the following:
 - a. Aromatherapy.
 - b. Hypnotism.
 - c. Massage therapy services when: services are not prescribed by a Physician; prior Authorization is not obtained; or services are not performed by a healthcare Provider who is acting within the scope of his license.
 - d. Rolfing.
 - e. Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM).
8. Comfort or Convenience Items including:
 - a. Television.
 - b. Telephone.
 - c. Beauty/Barber service.
 - d. Guest service.

9. 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.

D. THIRD PARTY/PLAN PARTICIPANT RESPONSIBILITY OR FAULT

1. 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 regardless of whether or not coverage under such laws or programs is actually in force or whether the patient has filed a claim for benefits.
2. 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 occurring as a result of a Plan Participant's commission or attempted commission of a felony.
 - c. treatment of any Plan Participant detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention; or
 - d. health services for treatment of military service-related disabilities, when the Plan Participant is legally entitled to other coverage and facilities are reasonably available.

E. DENTAL/VISION/HEARING

1. Dental and orthodontic services, appliances, supplies, and devices, including, but not limited to the following:
 - a. Dental braces and orthodontic appliances, except as specifically provided in this Benefit Plan.
 - b. Treatment of periodontal disease.
 - c. Dentures, dental implants, and any Surgery for their use, except if needed as the result of an accident that meets this Benefit Plan's requirements.
 - d. Treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in this Benefit Plan.
 - e. Expenses incurred for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, as specifically set forth herein, dental procedures which fall under the guidelines of treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral maxillofacial surgeries which are shown to the satisfaction of the Claim's Administrator to be Medically Necessary, non-dental, non-cosmetic procedures.
2. Diagnosis, treatment or Surgery of dentofacial anomalies including but not limited to, malocclusion, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition, except as specifically provided in this Benefit Plan.
3. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - a. Extraction, restoration and replacement of teeth.
 - b. Medical or surgical treatments of dental conditions.

- c. Services to improve dental clinical outcomes.
- 4. Dental implants.
- 5. Dental braces.
- 6. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
 - a. Transplant preparation.
 - b. Initiation of immunosuppressives.
 - c. The direct treatment of acute traumatic Injury, cancer or cleft palate.
 - d. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.
- 7. Routine eye examinations, glasses and contact lenses, except as specifically provided for in this Benefit Plan.
- 8. Services, Surgery, supplies, treatment or expenses related to:
 - a. eyeglasses or contact lenses, unless shown as covered as provided in this Benefit Plan.
 - 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. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser Surgery; or
 - e. visual therapy.
- 9. Eye exercise therapy.
- 10. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye Surgery.
- 11. Routine vision examinations, including refractive examinations.

F. DURABLE MEDICAL EQUIPMENT AND RELATED ITEMS

- 1. Correction or orthotic or inserts shoes and related items, such as wedges, cookies, and arch supports.
- 2. Glucometers.
- 3. Augmentative communication devices.
- 4. Any Durable Medical Equipment, items and supplies over reasonable quantity limits as determined by this Benefit Plan; all defibrillators other than implantable defibrillators authorized by the Claims Administrator.
- 5. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- 6. Services or supplies for the prophylactic storage of cord blood.

7. Storage of tissue, organs, fluids or cells, with the exception of autologous bone marrow, the storage of which will be covered for a period not to exceed thirty (30) days.
8. Devices used specifically as safety items or to affect performance in sports-related activities.
9. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces.)
10. Enteral feedings and other nutritional and electrolyte supplements, including infant formula.
11. Oral appliances for snoring.
12. Medical supplies not specifically provided for in this Benefit Plan.

G. REPRODUCTIVE/FERTILITY

1. Maternity expenses incurred by any person other than the Employee or the Employee's Spouse.
2. Artificial organ implants, penile implants, transplantation of non-human organs, and any surgery and other treatment, services, or supplies, related to such procedures, or to Complications related to such procedures.
3. Expenses subsequent to the initial diagnosis for infertility and Complications, including but not limited to, services, drugs, procedures, or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, donor eggs, and reversal of sterilization procedures.
4. Elective medical or surgical abortion unless:
 - a. the pregnancy would endanger the life of the mother; or
 - b. the pregnancy is a result of rape or incest; or
 - c. the fetus has been diagnosed with a lethal or otherwise significant abnormality.
5. 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 intra fallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.
6. Prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.
7. Paternity tests and tests performed for legal purposes.

H. HABILITATIVE

1. Services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, and dietary or educational instruction for all diseases and/or illnesses, except diabetes.
2. Counseling services, including but not limited to, marriage counseling, family relations counseling, divorce counseling, parental counseling, pastoral counseling, employment counseling and career counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.
3. Services of a licensed speech therapist when services are not prescribed by a Physician and prior Authorization is not obtained.
4. Services of a licensed speech therapist when services are provided for any condition, except for the following: restoring partial or complete loss of speech resulting from stroke, Surgery, cancer, radiation

laryngitis, cerebral palsy, accidental injuries, or other similar structural or neurological disease and Autism Spectrum Disorders.

5. Services, Surgery, supplies, treatment or expenses for the following REGARDLESS OF CLAIM OF MEDICAL NECESSITY:
 - a. Biofeedback.
 - b. 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 value-added services and may be subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the programs;
 - c. wilderness camp/programs except when provided by a qualified Residential Treatment Center and approved by Us as Medically Necessary for the treatment of Mental Health conditions or Substance Use Disorders;
 - d. treatment related to sexual inadequacies, except for the diagnosis and/or treatment of sexual dysfunction/impotence.
 - e. treatment related to sex transformations.
 - f. industrial testing or self-help programs (including, but not limited to supplies and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations, etc., except services required to be covered by law.
 - g. recreational therapy; or
 - h. services performed primarily to enhance athletic abilities.
6. Educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This includes Applied Behavior Analysis services that are not habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or Custodial Care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law.
7. Medically Necessary home or laboratory sleep studies and associated professional Claims are covered.
8. Applied Behavior Analysis that the Claims Administrator has determined is not Medically Necessary. The following is also excluded: Applied Behavior Analysis rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.
9. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
10. Tuition for or services that are school-based for Children and adolescents under the Individuals with Disabilities Education Act.
11. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
12. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

I. ORGAN TRANSPLANT

1. 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 except as approved by the Claims Administrator (porcine valve).
 - 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.
2. Health services for transplants involving mechanical or animal organs.
3. Transplant services that are not performed at a Network facility that is specifically approved by the Claims Administrator to perform organ transplants.
4. Any solid organ transplant that is performed as a treatment for cancer.

J. PRESCRIPTIONS/DRUGS

1. REGARDLESS OF CLAIM OF MEDICAL NECESSITY, Benefits for prescription or supplements intended for weight management or nutrition after the Bariatric Surgery are excluded.
2. Vitamins, dietary supplements and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g., phenylketonuria (PKU) unless required by law.
3. 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 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.
4. Prescription Drugs for which coverage is available under the Prescription Drug Benefit, unless administered during an Inpatient or Outpatient stay or those that are Medically Necessary requiring parenteral administration in a Physician's office.

K. MENTAL HEALTH/SUBSTANCE USE DISORDER

1. Methadone treatment as maintenance, L.A.A.M. (1-Alpha- Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
2. Substance Use Disorder Services for the treatment of caffeine use.
3. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

4. Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Claims Administrator.
6. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or Substance Use Disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - a. not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - b. not consistent with services backed by credible research soundly demonstrating that the services or supplies will have measurable and beneficial health outcome, and therefore are considered experimental.
 - c. typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
 - d. not consistent with the level of care guidelines or best practices as modified from time to time, or
 - e. not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, Substance Use disorder or condition based on generally accepted standards of medical practice and benchmarks.
7. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
8. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the Claims Administrator.
9. Services provided in a Residential Treatment Center for the active treatment of specific impairments of Mental Health or Substance Use Disorder, except as specifically provided in this Benefit Plan.
10. Treatment or services for Mental Health and Substance Use Disorder provided outside the treatment plan developed by the behavioral health Provider. Services, supplies and treatment for services that are not covered under this Benefit Plan and Complications from services, supplies and treatment for services that are not covered under this Benefit Plan are excluded.

ARTICLE XVII.

COORDINATION OF BENEFITS

A. Applicability

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

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

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

1. Allowable Expense Healthcare services or expenses, including 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 expense or a portion of a service or expense that is not covered by any of the Plans covering a Plan Participant is not an Allowable Expense.
 - b. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.
 - c. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the plans provides coverage for private hospital room expenses.
 - d. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.
 - e. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - f. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits 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 medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
2. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is the Secondary Plan.
3. Order of Benefit Determination

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

a. Non-Dependent or Dependent provision

The Plan that covers the person other than as a Dependent for example, as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent (e.g., 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 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 COB. 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.

ARTICLE XVIII. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

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

A. This Benefit Plan

1. To the extent that this Benefit Plan may be an Employee welfare Benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be The Office of Group Benefits 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 that the Claims Administrator specifically undertake 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 Participant's health status or a health status-related factor.
3. The Office of Group Benefits 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 Office of Group Benefits 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 Office of Group Benefits 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.

7. The Plan Administrator will not discriminate on the basis of race, color, religion, national origin, disability, sex, age, protected veteran or disabled status or genetic information; and shall not impose eligibility rules or variations in premium based on a Plan Participant's health status or a health status-related factor.

B. Amending and Terminating the Benefit Plan

OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Employee, whether active or retired.

Any provision of the Plan which, on its effective date, is in conflict with applicable state law provisions (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

C. Employer Responsibility

It is the responsibility of the Participant Employer to submit enrollment and change forms and all other necessary documentation to the Plan Administrator on behalf of its Employees. Employees of a Participant Employer will not, by virtue of furnishing any documentation to the Plan Administrator, be considered agents of the Plan Administrator, and no representation made by any such person at any time will change the provisions of this Plan.

D. Identification Cards and Benefit Plans

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

Unless otherwise agreed between the Group and the Claims Administrator, the Group has the sole responsibility for distributing all such documents to covered Employees.

E. Benefits 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 termination of a contractual agreement with a Provider, notification of the removal of the Provider from a 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 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) Scheduling 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 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 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 Network.
 - (5) The Plan Participant's condition does not meet the requirement to be deemed a Serious and Complex Condition.

F. Retroactive Cancellation of Coverage

1. The Plan Administrator may retroactively cancel coverage in the following instances:
 - a. To the extent the cancellation of coverage is attributable to a failure of the Plan Participant to timely pay required premiums, contributions and surcharges toward the cost of coverage; or
 - b. The cancellation of coverage is initiated by the Plan Participant.
2. When the Plan Administrator retroactively cancels coverage, the Plan Participant shall be liable to the Plan Administrator for all benefits paid on behalf of the Plan Participant after the effective date of rescission or cancellation of coverage.

G. Termination of a Plan Participant's Coverage Due to Fraud

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 form. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed or covered Plan Participant, shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective date of coverage, or terminated within three (3) years of the Plan Participant's Effective Date, for fraud or intentional misrepresentation of material fact. The Plan will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If You enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

H. Reinstatement to Position Following Civil Service Appeal

1. Self-Insured Plan Participants

When coverage of a terminated Employee, who was a participant in a self-insured health plan, is reinstated by reason of a civil service appeal, coverage will be reinstated to the same level in the Plan retroactive to the date coverage terminated. The Employee and Participant Employer are responsible for the payment of all premiums for the period of time from the date of termination to the date of the final order reinstating the Employee to his position. The Plan is responsible for the payment of all eligible benefits for charges incurred during this period. All claims for expenses incurred during this period must be filed with the Plan within 60 days following the date of the final order of reinstatement.

2. Fully Insured Health Maintenance Organization (HMO) Participants

When coverage of a terminated Employee, who was a participant in a fully insured HMO, is reinstated by reason of a civil service appeal, coverage will be reinstated in the HMO in which the Employee was participating effective on the date of the final order of reinstatement. There will be no retroactive reinstatement of coverage and no premiums will be owed for the period during which coverage with the fully insured HMO was not effective.

I. Filing Claims

1. All Claims must be filed within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than twelve (12) months from the date services were rendered.
2. Most Plan Participants that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Plan Participant. However, if the Plan Participant must file a Claim to access his Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to the Claims Administrator, may require the signature of the dispensing pharmacist. The claim form should then be sent to the Claims Administrator's Pharmacy Benefit Manager, whose telephone number can be found on the Plan Participant's ID card.

J. Release of Information

The Claims Administrator may request that the Plan Participant or the Provider furnish certain information relating to the Plan Participant's Claim for Benefits.

The Claims Administrator will hold such information, records, or copies of records as confidential except wherein the Claims Administrator's discretion the same should be disclosed.

K. Plan Participant/Provider Relationship

1. The selection of a Provider is solely the Plan Participant's responsibility.
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. The Plan and the Claims Administrator will not 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 Network and Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

L. 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 Plan Administrator's records. Any notice that a Plan Participant is required to give to the Plan Administrator must be given at the Plan Administrator's address as it appears in this Benefit Plan. The Plan or a Plan Participant may, by written notice, indicate a new address for giving notice.

M. 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.

N. Subrogation and Reimbursement

Upon payment of any eligible Benefits covered under this Plan, the Office of Group Benefits plan shall succeed and be subrogated to all rights of recovery of the Plan Participant or his/her heirs or assigns for whose benefit payment is made and the Plan Participant shall execute and deliver instruments and papers and do whatever is necessary to secure such rights and shall do nothing to prejudice such rights. The Office of Group Benefits shall have an automatic lien against and shall be entitled, to the extent of any payment made to a Plan Participant and/or his/her heirs or assigns, to 100% of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a Plan Participant and/or his/her heirs or assigns against any person or entity legally responsible for the disease, illness, accident, or injury for which said payment was made.

To this end, Plan Participants agree to immediately notify the Office of Group Benefits or its agent assigned to exercise reimbursement and subrogation rights on its behalf of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident, or injury. These subrogation and reimbursement rights also apply, BUT ARE NOT LIMITED TO, when a Plan Participant recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

Under these subrogation and reimbursement rights, the Office of Group Benefits has a right of first recovery to the extent of any judgment, settlement, or any payment made to the Plan Participant and/or his/her heirs or assigns. These rights apply whether such recovery is designated as payment for pain and suffering, medical benefits, or other specified damages, even if the Plan Participant is not made whole (i.e., fully compensated for his/her injuries).

O. 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.

P. 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.

Q. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan of Benefits constitutes a contract solely between the Plan Administrator and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana 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 Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Plan Administrator, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Plan Administrator for any of Blue Cross and Blue Shield of Louisiana's obligations 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.

R. 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/HMO Louisiana, Inc. 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 the Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. service area, You will receive it from one of two kinds of Providers, either Participating or Non-Participating Providers. Most Participating Providers contract with the local Blue Cross and/or Blue Shield Licensee in

that geographic area (Host Blue). Non-Participating Providers do not contract with the Host Blue. We explain below how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, 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 Us to provide the specific service or services.

1. BlueCard® Program

Under the BlueCard® Program, when Plan Participants access covered health care services in the geographic area that a Host Blue serves, the Claims Administrator will remain responsible for doing what We agreed to do in the contract. But the Host Blue must contract with and generally handle all interactions with its Participating Providers.

When You receive Covered Services outside Our service area and the Claim is processed through the BlueCard® Program, the amount Plan Participants pay for the Covered Services is calculated based on the following, as determined by Us:

- the billed covered charges for Your Covered Services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.
- an amount determined by applicable law.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare Provider or Provider group that may include types of settlements, incentive payments, and/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 Providers after taking into account the same types of transactions as with an estimated price.

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

2. Special Case: Value-Based Programs

a. BlueCard® Program

Under a Value-Base Program, if You receive Covered Services in a Host Blue’s service area, You will not have to pay any of the Provider Incentives, risk-sharing, or Care Coordinator Fees that are 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 a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on Your behalf, We will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees for the BlueCard® Program.

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

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If it applies, 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 the Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. Service Area

a. Plan Participant Liability Calculation

When Covered Services are provided outside of the Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. service area by Non-Participating Providers, We will normally base the amount You pay on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements that state law requires. In these situations, You may have to pay the difference between the amount that the Non-Participating Provider bills and how much the Claims Administrator pays for the Covered Services as stated in this paragraph. Federal or state law, may govern payments for Non-Network Emergency Medical Services.

b. Exceptions

In certain situations, the Claims Administrator may use other payment methods, such as billed charges for Covered Services, to determine the payment We would make if the health care services had been obtained within the Blue Cross and Blue Shield of Louisiana Inc. service area, or a special negotiated payment to determine the amount We will pay for services from Non-Participating Providers. In these situations, You may have to pay the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as stated in the Plan.

5. Blue Cross Blue Shield Global® Core

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (BlueCard® service area), You may be able to take advantage of the Blue Cross Blue Shield Global® Core for Covered Services. The Blue Cross Blue Shield Global® Core Program is unlike the BlueCard® Program in certain ways. For instance, although the Blue Cross Blue Shield Global® Core helps You access a network of Inpatient, Outpatient and professional Providers, Host Blue does not serve the network. When You go to Providers outside the BlueCard® service area, You will typically have to pay the Providers and submit the Claims Yourself.

For medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, call:

Blue Cross Blue Shield Global® Core service center
twenty-four (24) hours a day, seven (7) days a week.
1.800. 810.BLUE (2583)
1-800-810-2583,
or call collect at 1.804.673.1177

Working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global® Core Service Center for help and the Provider agrees to accept a guaranteed payment, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible Amount and Coinsurance. The Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center. But, if the Provider does not agree to a guaranteed payment or You otherwise paid in full when You received services, You must submit a Claim to be reimbursed. You must contact the Claims Administrator for Authorization for non-Emergency Inpatient services, as explained in the Care Management Article and meet other requirements in Your Plan for services to be provided, including, but not limited to, receiving only Medically Necessary services.

b. Outpatient Services

If You go to Physicians, Urgent Care Centers and other Outpatient Providers outside the BlueCard® service area typically require You must pay in full when You receive a service. To be reimbursed You must submit a Claim.

Exceptions

In situations where the Blue Cross Blue Shield Global® Core service center is unable to obtain a guaranteed payment for a Global® Core claim, We may use other payment methods to figure the payment We will make for the healthcare services that were delivered outside Our service area. Those other payment methods include, but are not limited to, billed charges for Covered Services, the payment We would make if the healthcare services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services from Non-Participating Providers. In these situations, You need to comply with the requirements of Your Benefit Plan and You may have to pay the difference between the amount that the Provider bills and the payment We will make for the Covered Services.

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

When You pay for Covered Services outside the BlueCard® service area, You must submit a Claim to obtain reimbursement. For institutional and professional Claims, fill out a Blue Cross Blue Shield Global® Core Claim form. Send the form with the Provider's itemized bills to the Blue Cross Blue Shield Global® Core service center at the address on the form.

Make sure to follow the instructions on the form. For a copy of the form, contact Us or the Blue Cross Blue Shield Global® Core service center, or go to www.bcbsglobalcore.com.

For help submitting Your Claim, call:

Blue Cross Blue Shield Global® Core service center
twenty-four (24) hours a day, seven (7) days a week.
1.800.810.BLUE (2583)
1-800-810-2583,
or call collect at 1.804.673.1177

S. 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.

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

The Plan Administrator shall provide to certain Plan Participants who have Prescription Drug coverage under this 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. The Claims Administrator will provide these Certificates to Plan Participants who are eligible for Medicare Part D based upon enrollment data.

The Plan 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.

U. Compliance with HIPAA Privacy Standards

The Plan Administrator's workforce performs services in connection with administration of the Plan. In order to perform these services, it is necessary for these workforce members, 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 workforce members are permitted to have such access subject to the following:

1. General

The Plan shall not disclose Protected Health Information to any member of the Plan Administrator'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 condition of a Plan Participant, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

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

3. Authorized Workforce Members

The Plan shall disclose Protected Health Information on to members of the Plan Administrator'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, "members of the Plan Administrator's workforce" shall refer to all workforce members and other persons under the control of the Plan Administrator.

State of Louisiana, Office of Group Benefits staff, contractors, and designees are authorized to receive Protected Health Information in order to perform their respective duties.

- a. **Updates Required.** The Plan Administrator shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
- b. **Use and Disclosure Restricted.** An authorized workforce member of the Plan Administrator'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 member of the Plan Administrator'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) investigating 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
 - (3) documenting the incident and all actions taken to resolve the issue and mitigate any damages.
- 4. Certification of Participant Employer/Plan Sponsor

The Participant Employer 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 Participant Employer and Plan Administrator 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 Participant Employer.
- d. report 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 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 the Participant Employer, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

V. 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 Plan Administrator agrees to the following:

1. The Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 workforce members and (4) Certification of Plan Administrator described above in this Article.

W. 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 Group are better able to afford benefit 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 costs, 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 XIX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

OGB Eligibility Appeal Process

OGB retains the authority to make all determinations regarding eligibility, except for rescissions of coverage determinations and those determinations involving medical judgment regarding the incapacity of Over-Age Dependents. All eligibility appeals other than those for rescissions of coverage determinations and those determinations involving medical judgment regarding the incapacity of Over-Age Dependents must be submitted within 180 calendar days following the denial of coverage to State of Louisiana Office of Group Benefits, Post Office Box 44036, Baton Rouge, Louisiana 70804 (rather than Blue Cross and Blue Shield of Louisiana), and OGB shall have sixty (60), rather than thirty (30), calendar days in which to respond to the appeal. Rescissions of coverage determinations and those determinations regarding the incapacity of Over-Age Dependents shall be subject to the procedures set forth in Section C below.

A. COMPLAINTS AND GRIEVANCES: Quality of Care or Services

The Claims Administrator wants to know when a Plan Participant is dissatisfied with the quality of care or services received from the Claims Administrator or a Network Provider. If a Plan Participant or his Authorized Representative wants to register an oral Complaint or file a formal written Grievance about the quality of care or services received from the Claims Administrator or a Network Provider, he should refer to the procedures below.

1. Complaints

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

To make a Complaint, call the Claims Administrator's customer service department at 1-800-392-4089. The Claims Administrator will attempt to resolve the Complaint at the time of the call.

If a Plan Participant or their Authorized Representative is dissatisfied with the Claims Administrator's resolution, he may file a first level Grievance.

2. Grievances

A Grievance is a **written** expression of dissatisfaction with the quality of care or services received from the Claims Administrator or a Network Provider.

To file a first level Grievance, send the first level Grievance to:

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
Appeals/Grievances Department
P.O. Box 98045
Baton Rouge, LA 70898-9045

The Claims Administrator's customer service department will assist the Plan Participant or their Authorized Representative with filing the first level Grievance, if necessary.

The Claims Administrator will mail a response to the Plan Participant or his Authorized Representative within thirty (30) calendar days from the date the Claims Administrator receives the first level Grievance.

B. INFORMAL RECONSIDERATION: Pre-Service Denial Based on Medical Necessity or Investigational Determinations

In addition to the appeal rights, the Plan Participant's Provider may initiate an Informal Reconsideration to review Utilization Management decisions.

Informal Reconsideration

An Informal Reconsideration is a process to review Utilization Management decisions and is initiated by a request by telephone, made by an authorized Provider to speak to the Claims Administrator's Medical Director or to a peer reviewer. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

An Informal Reconsideration is available only if requested within **ten (10) calendar days** of the date of the initial denial or adverse Concurrent Review determination. The Claims Administrator will conduct the Informal Reconsideration within **one (1) business day** from the receipt of the request. Once the Informal Reconsideration is complete, the Claims Administrator will advise the Plan Participant or his Authorized Representative of the decision and, if necessary, the Plan Participant's additional appeal rights.

C. APPEALS: Standard Appeal, External and Expedited Appeals

A Plan Participant may be dissatisfied with coverage decisions made by the Claims Administrator. For example, rescissions of coverage, denied Authorizations, Investigational determinations, adverse Medical Necessity determinations, Adverse Benefit Determinations based on medical judgment, denied Benefits (in whole or in part), or adverse Utilization Management decisions.

A Plan Participant's appeal rights, including a right to an expedited appeal, are outlined below.

Standard Appeals Process

An Appeal is a **written** expression of dissatisfaction with coverage decisions made by the Claims Administrator. A Plan Participant or his Authorized Representative may file an administrative Appeal or a medical Appeal. The Plan Participant or his Authorized Representative is encouraged to submit written comments, documents, records, and other information relating to adverse coverage decisions.

If the Plan Participant or his Authorized Representative has questions or needs assistance putting an Appeal in writing, or wishes to communicate with the Claims Administrator regarding an Appeal, he may call the Claims Administrator's customer service department at 1-800-392-4089.

MULTIPLE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED, AT ANY LEVEL OF REVIEW.

The appeal process has two (2) mandatory levels of review. At each level of review, the review will involve persons who did not participate in any prior Adverse Benefit Determination and who are not a subordinate to any previous adverse decision-maker. When the Appeal requires medical judgment, the review will involve a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Administrative Appeals

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

1. First Level Administrative Appeal

If the Plan Participant is not satisfied with the Claims Administrator's decision, a written request must be submitted within **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination for first level administrative Appeals. Request 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 denied, 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 Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of receipt of the Plan Participant's request: unless the Claims Administrator and Plan Participant mutually agreed that an extension of the time is warranted.

All administrative Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
Appeals/Grievances Department
P.O. Box 98045
Baton Rouge, LA 70898-9045

2. Second Level Administrative Appeal

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 receipt of the first level Appeal decision. Requests submitted after sixty (60) calendar days of receipt of the first level Appeal decision will not be considered.

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

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

Send a written request for further review and any additional information to:

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
Appeals/Grievances Department
P.O. Box 98045
Baton Rouge, LA 70898-9045

3. OGB Voluntary Level Appeal

Not applicable to a rescission of coverage appeal or any appeal requiring medical judgment. These appeals follow the second level external review track for medical appeals.

The Plan Participant or his Authorized Representative has **thirty (30) calendar days** from receipt of the notice denying the second level administrative Appeal to file an OGB voluntary level Appeal. **To file an OGB voluntary level Appeal**, send the OGB voluntary level Appeal to:

Office of Group Benefits
Administrative Claims Committee
P. O. Box 44036
Baton Rouge, LA 70804

along with copies of all information relevant to the Appeal. 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. Blue Cross and Blue Shield of Louisiana, Claims Administrator, Appeals and Grievance Unit, P. O. Box 98045, Baton Rouge, LA 70898-9045.

If the Administrative Claims Committee (ACC) grants the OGB voluntary level Appeal, the Plan Participant will be notified, and the Claims Administrator will reprocess the claim. If the ACC denies the OGB voluntary level Appeal, the ACC will notify the Plan Participant or his Authorized Representative, in writing, of the decision within sixty (60) calendar days from the date the ACC received the OGB voluntary level Appeal, or as allowed by law.

Medical Appeals Process

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

All medical Appeals should be submitted in writing to:

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

1. First Level Internal Medical 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) calendar days** of receipt of the initial Adverse Benefit Determination for internal medical Appeals. Requests submitted to the Claims Administrator after **one hundred eighty (180) calendar days** of receipt of the initial Adverse Benefit Determination will not be considered.

A healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, the Claims Administrator will reprocess the Plan Participant's Claim, if any. If the internal medical Appeal is upheld, the Claims Administrator will inform the Plan Participant of 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 receipt of the Plan Participant's request; unless the Claims Administrator and Plan Participant mutually agreed that an extension of the time is warranted.

If the first level Appeal is denied or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative may request a Second Level Appeal (External Review).

2. Second Level Medical / External Appeals

If the Plan Participant still disagrees with the determination on his Claim, or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative must send a written request for an external Appeal, conducted by a non-affiliated Independent Review Organization (IRO), within four (4) months of receipt of the internal Appeal decision, to:

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

Requests submitted to the Claims 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 Your Provider will not be accepted without this form completed with Your signature.**

The Claims Administrator will conduct a preliminary review to determine whether the Plan Participant has a right to an external review within five (5) business days of receiving the request. The Claims Administrator will notify the Plan Participant or his Authorized Representative, in writing, of the decision and requirements for any further action by the Plan Participant or his Authorized Representative within one (1) business day after completing the preliminary review.

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

The IRO decision is considered final and binding.

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

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 service 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/HMO Louisiana, Inc.
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

1. Expedited Internal Medical Appeals

In these cases, We will make a decision no later than seventy-two (72) hours of Our receipt of the internal medical Expedited medical Appeal request that meets the criteria for Expedited Internal medical 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 medical Appeal.

If the internal medical Expedited I 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 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 medical Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

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

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

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

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

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

1. NSA Internal Appeals

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

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

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
Appeals/Grievances Department
P.O. Box 98045
Baton Rouge, LA 70898-9045

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

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

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

2. NSA External Appeals

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

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

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

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
Appeals/Grievances Department
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 Blue Cross and Blue Sheild of Louisiana/HMO Louisiana, Inc. 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.

E. Exhaustion

The Plan Participant will have exhausted his administrative remedies under the Plan when the Plan Participant completes any one of the following steps:

- The OGB Eligibility Appeal process.
- Pharmacy Benefit Manager Appeal process.
- The Second Level Expedited Appeal process.
- The Second Level Internal Appeal process.
- The OGB Voluntary Level Appeal process; or,
- The External Review processes.

After exhaustion, a claimant may pursue any other legal remedies available to him.

F. Legal Limitations

A Plan Participant must exhaust his administrative remedies before filing a legal action. A lawsuit related to a claim must be filed no later than twelve (12) months after the claim is required to be filed, or more than thirty (30) calendar days after the Plan Participant has exhausted his administrative remedies, whichever is later.

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.

ARTICLE XX. OBTAINING 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 Claims Administrator's regional offices. 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/HMO Louisiana, Inc. 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 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 PPO Network Providers.
3. Use a designated PPO Network Provider to receive the highest level of Benefits.
4. Present the Plan Participant's ID card to the Provider, 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/HMO Louisiana, Inc.

B. 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. Network 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 Blue Cross and Blue Shield of Louisiana ID card shows the name of the Employee as it appears on the Claims Administrator's records. The ID card also lists the Plan Participant's ID number. 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 the appropriate Claim form is used, and includes following:

1. Full name of the patient.
2. Plan Participant ID number, as shown on the ID card.
3. Patient's date of birth.
4. Patient's relationship to the Employee.

5. All services are itemized, with the appropriate diagnosis and procedure codes and descriptions, for each service/treatment rendered, along with the charge for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form).
6. Date(s) of service /date(s) of treatment is correct.
7. Name and address of Provider of service/treatment.
8. Signed by the Plan Participant and the Provider.

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

C. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

When a Plan Participant is being admitted to a Network Provider, Hospital or Allied Health Facility, the Plan Participant should show his Blue Cross and Blue Shield 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 Network 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 Non-Network 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 Member ID number, the patient's date of birth, as well as the patient's relationship to the Employee. The Provider must mark the bill 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 his ID card to the admitting clerk. The Provider will file the Claim with Us. Benefit payment will be sent directly to the Provider. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

4. Prescription Drug Claims

Most Plan Participants with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Plan Participants who present an ID card to a Participating Pharmacist. However, if the Plan Participant must file a Claim to access his Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. Plan Participants may obtain the Prescription Drug Claim form by accessing the pharmacy section of Our website, www.bcbsla.com/pharmacy. The Prescription Drug Claim Form, or an attachment acceptable to the Claims Administrator, may require the signature of the dispensing pharmacist. The claim form should then be sent to the Claims Administrator or their Pharmacy Benefit Manager, whose telephone number can be found on the Plan Participant's ID card. Benefits will be paid to the Plan Participant based on the Allowable Charge for the Prescription Drug.

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 Disorders, the Plan Participant should refer to the ID card or call the Claims Administrator's customer service department.

7. Other Medical Claims

When the Plan Participant receives other medical services from clinics, Provider offices, etc., he should ask if the Provider is a Network Provider. If yes, this Provider will file the Plan Participant's Claim with the Claims Administrator. In some situations, the Non-Network Provider 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 it to the Claims Administrator.

If the Plan Participant is filing the Claim, the Claim must contain the information listed in section B., above. Itemized bills submitted with claim forms must include the following:

- a. full name of patient.
- b. date(s) of service.
- c. all services itemized, with the appropriate diagnosis and procedure codes and descriptions, for each service/treatment rendered, along with the charge for each service/treatment rendered.
- d. name and address of Provider of service.

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

D. 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 address below 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 information at hand, particularly the Member 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/HMO Louisiana, Inc.
5525 Reitz Avenue
P.O. Box 98027
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 XXI.

RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator Responsibility

The OGB will administer the Plan in accordance with its terms, state and federal law, the OGB's established policies, interpretations, practices, and procedures. The OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding eligibility for benefits and to decide disputes which may arise relative to a Covered Person's rights.

B. Amendments to or Termination of the Plan

OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Employee, whether active or retired.

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

D. 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 Office of Group Benefits.

GENERAL PLAN INFORMATION

NAME OF PLAN: Consumer Driven Health Plan for
State of Louisiana Employees

PLAN ADMINISTRATOR: State of Louisiana Office of Group Benefits
Post Office Box 44036
Baton Rouge, Louisiana 70804

(800) 272-8451

PLAN NUMBER (PN): 501

TYPE OF PLAN: Group Major Medical Benefit Plan

TYPE OF ADMINISTRATION: 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 Benefit Plan.

CLAIMS ADMINISTRATOR: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
5525 Reitz Avenue
Baton Rouge, LA 70809
(800) 392-4089

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. has been retained to process claims under the Plan. Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. does not serve as an insurer, but merely as a Claims processor. Claims for Benefits are sent to Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. processes and pays claims, then requests reimbursement from Plan. State of Louisiana, Office of Group Benefits is ultimately responsible for providing Plan Benefits, and not Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.

PLAN YEAR ENDS: December 31

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

FUTURE OF THE PLAN: Although the Plan Administrator expects and intends to continue the Benefit Plan indefinitely, the Plan Administrator reserves the right to modify, amend, suspend, or terminate the Benefit Plan at any time.

GENERAL NOTICE OF CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Introduction

This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of Group health coverage under certain circumstances when coverage would otherwise end under any of the Office of Group Benefits-sponsored health plans (hereinafter referred to as “Plan”). **This notice generally explains COBRA coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.** COBRA (and the description of COBRA coverage contained in this notice) applies only to the Group health plan benefits offered under the Plan and not to any other benefits offered by the State of Louisiana (such as life insurance).

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to You when You would otherwise lose Your Group health coverage under the Plan. It can also become available to Your Spouse and Dependent Children, if they are covered under the Plan, when they would otherwise lose their Group health coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about Your rights and obligations under the Plan and under federal law, You should get a copy of the Plan Document from the Plan. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand Your rights beyond COBRA’s requirements.

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Office of Group Benefits, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” You, Your Spouse, and Your Dependent Children could become qualified beneficiaries and would be entitled to elect COBRA coverage if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted Children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay the entire cost of COBRA coverage.

Who is entitled to elect COBRA Coverage?

If You are an Employee, You will be entitled to elect COBRA coverage if You lose Your Group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the Spouse of an Employee, You will be entitled to elect COBRA coverage if You lose Your Group health coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his or her gross misconduct; or
- You become divorced from Your Spouse. Also, if Your Spouse (the Employee) reduces or eliminates Your Group health coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for You even though Your coverage was reduced or eliminated before the divorce. If You notify the Office of Group Benefits within 60 days after the divorce and can establish that the Employee cancelled the coverage earlier in anticipation of the divorce, the COBRA coverage may be available for the period after the divorce.

A person enrolled as the Employee's Dependent Child will be entitled to elect COBRA coverage, if he or she loses Group health coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child."

When is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries only after the Office of Benefits has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the Employee, the Participant Employer must notify the Office of Group Benefits of the qualifying event within 30 days following the date coverage ends.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the Employee and Spouse, or a Dependent Child's losing eligibility for coverage as a Dependent Child), You must notify the Office of Group Benefits in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You must follow the notice procedures specified by the Office of Group Benefits. If notice is not provided to the Office of Group Benefits during the 60-day notice period, ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

Once the Office of Group Benefits receives timely notice of the qualifying event, it will forward the information to its third-party COBRA Administrator, who will notify You of Your right to elect COBRA coverage.

Electing COBRA

Once the Office of Group Benefits receives timely notice that a qualifying event has occurred, each qualified beneficiary will have an independent right to elect COBRA coverage. Once the Office of Group Benefits receives timely notice of the qualifying event, it will forward the information to its third-party COBRA Administrator, who will notify You of Your right to elect COBRA coverage. Covered Employees and Spouses (if the Spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their Children. **Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the covered Employee's divorce, or a Dependent Child's losing eligibility as a Dependent Child, COBRA coverage can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage under the Plan for his Spouse and Children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction in hours.

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Extension of COBRA Coverage

The COBRA coverage periods described above are maximum coverage periods. There are two ways in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration (or by the staff of the COBRA Administrator in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment) to be disabled and You notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in Your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered Employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first (61st) day after the Covered Employee's termination of employment or reductions of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

For persons eligible to receive Social Security disability benefits, the disability extension is available only if You notify the Office of Group Benefits and the COBRA Administrator in writing and submit a copy of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", the disability extension is available only if You submit to the COBRA Administrator in writing proof of total disability before the initial 18-month COBRA coverage period ends.

You must also provide this notice to the COBRA Administrator within 18 months after the covered Employee's termination of employment or reduction in hours in order to be entitled to a disability extension. In providing this notice, You must use the Plan's form entitled "Notice of Disability Form" (You may obtain a copy of this form from the COBRA Administrator at no charge, or You can download the form at www.tasconline.com), and You must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period and within 18 months after the Employee's termination of employment or reduction of hours, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA coverage because of the covered Employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the Spouse and Dependent Children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the Spouse and any Dependent Children receiving COBRA coverage if the Employee or former Employee dies, or gets divorced, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered Employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if You notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of:

- the date of the second qualifying event; and
- the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still an Employee covered under the Plan).

In providing this notice, You must use the COBRA Administrator's form, entitled "Notice of Second Qualifying Event Form" (You may obtain a copy of this form from the COBRA Administrator at no charge, or You can download the form at www.tasconline.com), and You must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator within the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered Employee during COBRA coverage period

A Child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The Child's COBRA coverage begins on the Child's date of birth, date of adoption, or date of placement for adoption if the Child is enrolled in the Plan through the HIPAA Special Enrollment process designated by OGB, or on the first day of the following Plan Year if the Child is enrolled through Annual Enrollment. The COBRA coverage lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A Child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Office of Group Benefits during the covered Employee's period of employment with the Participant Employer is entitled to the same rights to elect COBRA as an eligible Dependent Child of the covered Employee.

Health Insurance Marketplace

There may be other coverage options for You and Your family. Through the Affordable Care Act, You are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, You could be eligible for a tax credit that lowers Your monthly premiums right away, and You can see what Your premium, 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 for a tax credit through the Marketplace. Additionally, You may qualify for a special enrollment opportunity with 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 30 days.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

You may obtain information about the Plan and COBRA coverage on request from:

Plan Information: **Office of Group Benefits
Eligibility Department
Post Office Box 44036
Baton Rouge, Louisiana 70804
1.800.272.8451
225.342.9917 FAX**

COBRA Information: **Total Administrative Services Corporation
2302 International Ln
Madison, WI 53704-3140
800-422-4661
608-663-2753 (FAX)**

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, You and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms: Any notice that You provide must be in writing and must be submitted on the Plan’s required form (the Plan’s required forms are described above in this notice, and You may obtain copies from the COBRA Administrator without charge or download them at www.tasconline.com/mytasc-login). Oral notice, including notice by telephone, is not acceptable. Electronic e-mailed notices are not acceptable.

How, When, and Where to Send Notices: You must mail or FAX Your notice to:

**TASC COBRA
2302 International Ln
Madison, WI 53704-3140
608-663-2753 (FAX)**

If mailed, Your notice must be postmarked no later than the last day of the applicable notice period. If faxed, Your notice must be received by the Eligibility department at the number specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled “You Must Give Notice of Some Qualifying Events,” “Disability extension of COBRA coverage,” and “Second qualifying event extension of COBRA coverage.”)

Information Required for All Notices: Any notice You provide must include: (1) the name of the Plan; (2) the name and address of the Employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Notice Procedures (continued)

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce, Your notice must include a copy of the decree of divorce. If Your coverage is reduced or eliminated and later a divorce occurs, and if You are notifying the Office of Group Benefits that Your Plan coverage was reduced or eliminated in anticipation of the divorce, Your notice must include evidence satisfactory to the Office of Group Benefits that Your coverage was reduced or eliminated in anticipation of the divorce.

Additional Information Required for Notice of Disability: Any notice of disability that You provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination, if applicable; (5) a copy of the Social Security Administration's determination, if applicable; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled. For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", any notice of disability must also include proof of total disability, such as medical evidence presented by the applicant's physicians and the applicant's work history.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that You provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce, a copy of the decree of divorce.

Who May Provide Notices: The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.



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 بگیرید.

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)

