



**OFFICE OF GROUP BENEFITS
PELICAN HRA 1000 CDHP
FOR
STATE OF LOUISIANA EMPLOYEES**

provided by



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross
and Blue Shield Association.

5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802
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NON-GRANDFATHERED HEALTH BENEFIT PLAN

NOTICE

Health care services may be provided to You at a Network health care facility by facility-based physicians who are not in Your health plan's Network. You may be responsible for payment of all or part of the fees for those Non-Network services, in addition to applicable amounts due for Copayments, Coinsurance, Deductibles and Non-covered services.

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.

The Claims Administrator bases the payment of Benefits for the Plan Participant's Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom You receive Covered Services.

A handwritten signature in black ink that reads "Mike Reitz".

Mike Reitz
President and Chief Executive Officer
Louisiana Health Service & Indemnity Company

Blue Cross and Blue Shield of Louisiana Incorporated as Louisiana Health Service & Indemnity Company

PELICAN HRA 1000 CDHP

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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 and their enrolled Dependents. This Benefit Plan replaces any others previously issued to participants on the Benefit Plan Date or the amended Benefit Plan Date. This Plan describes Your Benefits, as well as Your rights and responsibilities under the Plan. You are encouraged to read this Benefit Plan carefully.

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

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

FACTS ABOUT THIS CONSUMER DRIVEN 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 a Plan Participant sets up 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 an 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 as stated in the Schedule of Benefits. After payment of applicable Deductibles, Benefits are subject to two (2) Coinsurance levels (for example: 80/20, 70/30). The Plan Participant's choice of a Provider determines what Coinsurance level applies to the service provided. The Plan will pay the highest Coinsurance level 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 Non-Network Provider.

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, check on-line at www.bcbsla.com/ogb, or 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 diagnostic 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.

RECEIVING CARE OUTSIDE OF THE NETWORK

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

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 does not apply to the Out-of-Pocket Maximum.

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

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 \$2500 Allowable Charge x 20% Coinsurance = \$500	\$750 \$2,500 Allowable Charge x 30% Coinsurance = \$1000
Plan Participant is billed up to the Provider's billed charge	NO	YES
TOTAL PLAN PARTICIPANT PAYS:	\$500	\$10,250

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.

No payment will be made for Organ, Tissue 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 in writing. To locate an approved transplant facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their ID card.

HOW THE PLAN DETERMINES WHAT IS PAID FOR COVERED SERVICES

When a Plan Participant Uses Network Providers

Network Providers are Providers who have signed contracts with the Claims Administrator or another Blue Cross and Blue Shield Plan to participate in the PPO Network. These Providers have agreed to accept the lesser of billed charges or an amount negotiated as payment in full for Covered Services provided to Plan Participants. This amount is the Network Provider's Allowable Charge. If the Plan Participant uses a Network Provider, this Allowable Charge is used to determine the Plan's payment for the Plan Participant's Medically Necessary Covered Services and the amount that the Plan Participant must pay for his Covered Services.

When a Plan Participant Uses Non-Network Providers

Non-Network Providers are Providers who have not signed a contract with the Claims Administrator or any other Blue Cross and Blue Shield plan to participate in a Blue Cross and Blue Shield PPO Network. These Providers are not in the Claims Administrator's Networks. The Claims Administrator has no fee arrangements with them. The Claims Administrator establishes an Allowable Charge for Covered Services provided by Non-Network Providers. The lesser of the Provider's actual billed charge or the established Allowable Charge is used to determine what to pay for a Plan Participant's Covered Services

when he receives care from a Non-Network Provider. The Plan Participant will receive a lower level of Benefit Payment because he did not receive care from a Network Provider.

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

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.

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.

PLAN PARTICIPANT INCENTIVES

Sometimes the Plan offers coupons, discounts, or other incentives to encourage Plan Participants to participate in various programs such as pharmacy programs, wellness programs, or disease management programs. A Plan Participant may wish to decide whether to participate after discussing such programs with his Physician. These incentives are not Benefits and do not alter or affect Plan Participant Benefits.

The Plan 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, 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 any risks based on their history and habits. Exclusive discounts are also available to Plan Participants on some health services such as fitness club memberships, diet and weight control programs, vision and hearing care and more.

CUSTOMER SERVICE

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.

HOW TO OBTAIN CARE USING BLUECARD® WHILE TRAVELING

THE PLAN PARTICIPANT'S ID CARD OFFERS CONVENIENT ACCESS TO PPO HEALTH CARE 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 (out of country) are covered at the Network Benefit level. Non-emergency services received outside of the United States (out of country) ARE COVERED AT THE NON-NETWORK BENEFIT LEVEL.

ARTICLE II.

DEFINITIONS

ACA and/or PPACA – The Patient Protection and Affordable Care Act of 2010, as amended.

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.

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.

Affordable Care Act - 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 nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, Physician's assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by Us to render Covered Services.

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

Allowable Charge – The lesser of the billed charge or the amount established by the Claims Administrator or negotiated as the maximum amount allowed for all Provider services covered under the terms of this Benefit Plan.

Alternate Facility - a health care 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 and equipped vehicle used only for transporting the sick and injured.

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/Retiree may enroll for Benefits under this Benefit Plan or any other Group Plan.

Appeal – A request from a Plan Participant or Authorized Representative to change a previous decision made by the Claims Administrator about Covered Services or an eligibility determination. Examples of issues that qualify as appeals include denied Authorizations, Claims based on adverse determinations of Medical Necessity or Benefit determinations.

Applied Behavior Analysis (ABA) - The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Providers of ABA shall be licensed or certified as a behavior analyst by the Behavior Analyst Certification Board or shall provide, upon request, documented evidence satisfactory to the Plan, of equivalent education, professional training, and supervised experience in ABA.

Authorization (Authorized) – A determination by the Claims Administrator regarding an Admission, continued Hospital stay, or other health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the health care 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. ASD includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified.

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

Benefits – Coverage for health care services, treatments, procedures, equipment, drugs, devices, items or supplies provided under this Plan. Benefits provided by the Plan are based on the Allowable Charge for Covered Services. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this Benefit Plan and any attached Riders and Amendments.

Benefit Payment - Payment of Eligible Expenses based on the Allowable Charge, at the percentage shown in 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 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.

Case Management – 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.

Child or Children includes:

1. A Child of the Employee;
2. A Child of the Employee's legal spouse;
3. A Child in the process of being adopted by the Employee through an agency adoption;
4. A Child under the guardianship or in the legal custody of the Employee;
5. A Grandchild of the Employee who is not in the legal custody of the Employee whose parent is a covered Dependent. If the Employee seeking to cover a Grandchild is a paternal grandparent, the Plan Administrator will require that the biological father, i.e. the covered son of the Employee, execute an acknowledgement of paternity.

Note: If the Dependent parent becomes ineligible for coverage under the Plan, the Grandchild will also be ineligible for coverage, unless the Employee has legal custody of his/her Grandchild.

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, and other rehabilitative measures for the purpose of correcting interference with normal nerve transmission and expression.

Claim – A 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 (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.

Complaint – An oral expression of dissatisfaction with the quality of care or services received from the Claims Administrator or a Network Provider.

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

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

Congenital Anomaly – A condition existing at or from birth, which significantly interferes with normal bodily function. A Congenital Anomaly is identified within the first twelve months of birth. For purposes of this Benefit Plan, the Plan will determine what conditions will be covered as Congenital Anomalies. In no event will the term Congenital Anomaly include conditions relating to teeth or structures supporting the teeth, except for cleft lip or cleft palate.

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

Covered Person - An Active Employee, his eligible Dependent(s), or any other individual eligible for coverage 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.

Creditable Coverage for HIPAA Portability - Prior coverage under an individual or group health plan, during which there was no break in coverage of 63 consecutive days or more. Individual and group health plans include, but are not limited to the following types of plans: Medicare, Medicaid, government plan, church plan, COBRA, military plan or State Children's Health Insurance Program (e.g. LaCHIP), a medical care program of the Indian Health Services Program or a tribal organization, a state health benefits risk pool, any public health benefit program provided by a state, county, or other political subdivision, a health benefit plan under the Peace Corps Act.

Creditable coverage does not include specific disease policies (i.e., cancer policies), supplemental coverage (i.e., Medicare Supplement) or limited benefits (i.e., accident only, disability insurance, liability insurance, workers' compensation, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics or coverage as specified in federal regulations under which benefits for medical care are secondary or incidental to the insurance benefits).

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to: personal care, feeding, dressing, bathing, homemaking, moving the patient; acting as companion or sitter; supervising medication that can usually be self-administered; treatment or services that any person may be able to perform with minimal instruction; or 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/Retiree is acquired in the following instance and on the following dates only:

1. Legal Spouse – the date of marriage;
2. Child or Children
 - a. Natural Children – the date of birth;
 - b. Children in the process of being adopted:

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;

- c. Child for whom the Employee has legal custody or guardianship – the date of the court order granting legal custody or guardianship or of the notarized act granting provisional custody;
- d. Grandchild of the Employee who is not in the legal custody of the Employee whose parent is a covered Dependent:
 - i. The date of birth of the Grandchild, if all of the above requirements are met at the time of birth;
or
 - ii. The date on which the coverage becomes effective for the covered Dependent, if all of the above requirements are not met at the time of birth.

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

Deductible Amount - The dollar amount the Plan Participant must pay within a Benefit Period before Benefit Payments are made by the Plan. The Annual Deductible applies to all Covered Health Services under the Plan as shown in the Schedule of Benefits.

- A. Individual Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, that an individual Plan Participant must pay within a Benefit Period before the Plan starts paying benefits. The Annual Deductible does not apply to Preventive and Wellness Care.
- B. Family Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, that Plan Participants in a class of coverage with more than one (1) Plan Participant must pay within the Benefit Period before this Plan starts paying Benefits. Once the Family Deductible Amount is met, the Individual Deductible Amount of all other Plan Participants of the family unit will be considered satisfied for that Benefit Plan, and this Plan starts paying Benefits for all Plan Participants of the family unit. For purposes of this Benefit Plan, “family” includes all Available Classes of Coverage, except single Plan Participant or Employee Only coverage.

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 legal Spouse;
- B. A Child from Date Acquired until attainment of age 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 legal Spouse - Certified copy of certificate of marriage indicating date and place of marriage.
- B. Child
 - 1. Natural or legally adopted child of Plan Participant - Certified copy of birth certificate listing Plan Participant as parent or certified copy of legal acknowledgment of paternity signed by the Plan Participant or certified copy of adoption decree naming Plan Participant as adoptive parent.
 - 2. Stepchild - Certified copy of certificate of marriage to spouse and birth certificate listing spouse as natural or adoptive parent.
 - 3. Child placed with Your family for adoption by agency adoption or irrevocable act of surrender for private adoption. Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender.
 - 4. Child for whom You have been granted guardianship or legal custody, including provisional custody - Certified copy of the signed court order granting legal guardianship or custody, or the original notarized act granting provisional custody in proper statutory form and substance.
 - 5. Grandchild for whom You do not have legal custody or guardianship whose parent is a covered Dependent - Certified birth certificate or adoption decree showing parent of grandchild is Dependent child and certified copy of birth certificate showing Dependent child is parent of grandchild.
- C. Child age twenty-six (26) or older who is incapable of self-sustaining employment and who was covered prior to and upon attainment of age twenty-six (26) - Documentation as described in B.1. through B.5. above, together with an application for continued coverage and supporting medical documentation which must be received by OGB prior to the child’s attainment of age twenty-six (26) as well as additional medical documentation of child’s continuing condition periodically upon request by OGB.
- D. Such other written proof of relationship to the Employee deemed sufficient by the Group.

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. DME includes, but is not limited to, items such as wheelchairs, hospital beds, respirators, braces (non-dental), and custom orthotics which must be specially made and not available at retail stores.

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

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

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 – Those medical services necessary to screen, evaluate and stabilize an Emergency Medical Condition.

Employee - A full-time Employee as defined by a Participant Employer and in accordance with state law.

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

Expedited Appeal – Any request from a Plan Participant, his Authorized Representative, or the Provider acting on behalf of the Plan Participant, for an urgent or emergent review of an adverse Benefit determination, when the time frame of the standard appeal process would seriously jeopardize the Plan Participant's life, health, and ability to regain maximum function; or, when, in the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a decision through the standard appeal process.

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

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.

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.

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

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

Hospice Care – Provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Plan Participants and their families during the final stages of terminal illness. 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 provided 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.

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

Independent Review Organization (IRO) – An independent review organization not affiliated with the Claims Administrator or the Plan Administrator that conducts external reviews of final adverse determinations. The decision of the IRO is binding on the Plan Participant, Plan Administrator and Claims Administrator.

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

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 U.S. 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
- C. whether the medical treatment, procedure, drug, device, or biological product demonstrates improved health outcomes according to the consensus of opinion among experts as shown by reliable evidence, including:
 - 1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);
 - 2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 - 3. reference to federal regulations.

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

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

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.

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.

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 Maximum – The maximum amount, as shown in the Schedule of Benefits, unreimbursable expenses which must be paid by a Plan Participant or Family Unit for Covered Services in one Benefit Period.

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.

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

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 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 – Any Employee who is covered under this Plan. An Eligible Person who is properly enrolled under the Plan.

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

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 health care 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 -

Health care 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), to provide continuous skilled nursing care, one-on-one for an individual patient.

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

Prosthetic Services – The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external

parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. Also includes medically necessary clinical care.

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

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.

Rehabilitative Care – Health care services 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 and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

The program must meet all of the following:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time Participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - room and board;
 - evaluation and diagnosis;
 - counseling; and
 - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

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

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 losing other comparable health coverage 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:

1. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.
2. Coordination of care is required prior to drug therapy initiation and/or during therapy.
3. Unique patient compliance and safety monitoring requirements.
4. Unique requirements for handling, shipping and storage.
5. 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, cognitive-communication and swallowing disorders, with the goals directed towards improving or restoring function.

Spouse – The Employee's legal spouse as determined pursuant to the Constitution of the State of Louisiana.

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

Substance Abuse Disorder Services - 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 Abuse 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.

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

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

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

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 that is in the network if a Plan Participant requires non-emergency medical care or a Plan Participant requires Urgent Care after normal business hours of a Plan Participant's Physician.

Urgent Care Center – A clinic with extended hours that provides Urgent Care and minor Emergency Care to patients for Covered Health Services that are required to prevent serious deterioration of Your health. The Covered Health Services are provided on an unscheduled basis without need for an appointment as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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 health care 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 health care services, procedures, and facilities; sometimes referred to as Utilization Management.

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 for the OGB health plans apply to all participants in OGB sponsored health plans including the self-funded PPO, HMO, Consumer Driven Health Plan and the Medical Home HMO plan and the OGB life insurance plan.

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.

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. Husband and Wife, 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) 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) 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 Open Enrollment period or Special Enrollment period.
- (4) An Employee who transfers employment to another Participating 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 Open Enrollment period or Special Enrollment period.
- (5) An Employee who is determined to be an FTE shall 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 month of employment for those Employees determined to be FTEs during their initial measurement period.

d. Re-Enrollment, Previous Employment for Health and Life Benefits

- (1) An Employee, whose employment terminated while covered and is re-employed within twelve (12) months of the termination date, will be considered a Re-Enrollment Previous Employment applicant. A Re-Enrollment Previous Employment applicant will only be eligible for the classification of coverage (Employee, Employee and child(ren), Employee and spouse, Family) in force on the effective termination date.
- (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

Legislative assistants are eligible to participate in the Plan if they are declared full-time Employees by the Participant Employer and have at least one year of experience or receive at least eighty-percent (80%) of their total compensation as Legislative assistants.

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 the covered Employee acquires a Dependent.
- b. Effective Dates of Coverage – Application for coverage must be made within thirty (30) days of eligibility for coverage.
 - (1) Documented Dependents of Employees - Coverage will be effective on the date of marriage for new spouses, the date of birth for newborn children, or the Date Acquired for other classifications of Dependents.

3. Special Enrollments - HIPAA

In accordance with HIPAA, certain Eligible persons for whom the option to enroll for coverage was previously declined may enroll by written application to the Plan Administrator under the following circumstances, terms, and conditions for special enrollments.

- a. Loss of Other Coverage - Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined because the Employees or Dependents had other coverage which terminated due to:
 - (1) Loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the Plan Participant; or
 - (2) Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer's contributions were ceased for cause or for failure of the individual participant to make contributions; or

- (3) The Employee or Dependent having had COBRA continuation coverage under a group health plan and the COBRA continuation coverage has been exhausted, as provided in HIPAA; or
 - (4) Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or
 - (5) Eligibility for premium assistance subsidy under Medicaid or SCHIP.
- b. After-Acquired Dependents - Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined when the Employee acquires a new Dependent by marriage, birth, adoption, or placement for adoption.
- (1) A special enrollment application must be made within thirty (30) days of either the termination date of the prior coverage or the date the new Dependent is acquired, or within sixty (60) days as identified in 3.a.(4) and 3.a.(5) above.

The Effective Date of coverage shall be:

- (a) For loss of other coverage or marriage, the first day of the month following the date the Plan Administrator receives all required forms for enrollment.
- (b) For birth of a Dependent, the date birth.
- (c) For adoption, the date of adoption or placement for adoption.

4. Health Maintenance Organization (HMO) Option

- a. In lieu of participating in the Plan, Employees may elect coverage under an OGB offered, fully insured HMO.
- b. New Employees may elect to participate in an HMO during their initial period of eligibility.
- c. Each HMO will hold an annual enrollment period for coverage effective date of January 1. Transfer of coverage from the Plan to the HMO or vice-versa will only be allowed during this Annual Enrollment period.
 - (1) Transfer of coverage will be allowed, other than at the Annual Enrollment period, when the Employee moves residences into or out of the HMO geographic service area, with an effective date of the first day of the month following notification to OGB of change of address.
- d. If a Covered Person has elected to transfer coverage but is hospitalized on January 1, the Plan providing coverage prior to January 1 will continue to provide coverage up to the date of discharge from the hospital.

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 participating employer shall continue to pay its portion of health plan premiums for up to twelve (12) months.

- (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 participating 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 participating employer shall continue to pay its portion of premiums.

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 in above in B.1., may continue to participate in an Office of Group Benefits benefit 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 legal 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 attainment of the termination age for children, 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 successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal 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/Retiree born after the Employee's/Retiree's death.

c. Participant Employer/Dependent Responsibilities

- (1) It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Plan Administrator within sixty (60) 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 premium 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 premium timely.
 - (ii) Eligibility of the surviving Dependent child for coverage under any group health plan other than Medicare; or
 - (iii) The attainment of the termination age for children.

- 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.

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, the coverage for the Dependent Child may be continued for the duration of incapacity.

- a. 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, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.
- b. Upon receipt of the application for continued coverage, the Plan Administrator may require additional medical documentation regarding the Dependent Child's incapacity as often as it may deem necessary.

5. Military Leave

Plan Participants of the National Guard or of the United States military reserves who are called to active military duty and their covered Dependents will have access to continued coverage under OGB's health and life plans.

- a. Health Plan Participation - When called to active military duty, Plan Participant and their covered 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 such Plan Participants 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;
 - (ii) the Dependent's date of discharge from active military duty; or
 - (iii) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Plan participants 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. 42:851E 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. It is the responsibility of the Participant Employer to notify the Plan Administrator within thirty (30) days of the date coverage would have terminated because of any of the foregoing events and the Plan 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 Plan Administrator within sixty (60) days of the date of the election notification, and premium payment must be made 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 premium 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 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. It is the responsibility of the Participant Employer or surviving covered Dependents to notify the Plan Administrator within thirty (30) days of the death of the Employee. The Plan Administrator will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification.
- c. Premium payment must be made 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 premium 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. Divorced Spouse

- a. Coverage under this Plan for an Employee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the Employee, unless the covered divorced spouse elects to continue coverage at his own expense.
- b. It is the responsibility of the divorced spouse to notify the Plan Administrator of the divorce within sixty (60) days from the date of the divorce. The Plan Administrator will notify the divorced spouse within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the election notification.
- c. 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. 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.

- d. Coverage for the divorced spouse under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premium 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. It is the responsibility of the Dependent child to notify the Plan Administrator of his election to continue coverage within sixty (60) days of the date coverage would have terminated. The Plan Administrator will notify the Dependent child within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of the election notification.
- c. Premium payment must be made 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 premium 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 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 own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

- b. It is the responsibility of the spouse and/or the Dependent child to notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.
- c. Monthly payments 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 premium 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 Plan 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 Social Security Administration's disability determination to the Plan 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 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 Plan Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the Plan 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 premium 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 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 Plan 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 premium 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 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

When the Employee will participate in COBRA continuation coverage with his/her Dependents which are qualified beneficiaries, the Employee and those Dependents that elect COBRA will continue the same HRA Account that they had when the Employee was active.

When the Employee will not participate in COBRA continuation coverage with his/her Dependents, the qualified beneficiaries that elect COBRA will be set up in a separate HRA Account until the end of their continuation coverage. Such separate HRA Account will have its own Accrual based on enrollment status, and its own Carryover features. HRA Accounts set for these qualified beneficiaries will not carryover any portion of the Available Amount from the original HRA Account.

D. Change of Classification

1. Adding or Deleting Dependents

The Plan Participant must notify the Plan Administrator when a Dependent is added to or deleted from the Plan Participant's coverage. Notice must be provided within thirty (30) days of the additions or deletions.

2. Change in Coverage

When there is a change in family status (e.g., marriage, birth of child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for coverage of the additional Dependent must be made within thirty (30) days of the date of the event.

When the addition of a Dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the fifteenth (15th) day of the month. If the date of change occurs on or after the fifteenth (15th) day of the month, an additional premium will not be charged until the first day of the following month.

3. Notification of Change

It is the Plan Participant's responsibility to notify the Plan Administrator of any additions or deletions of a Dependent. If failure to notify is later determined, it will be corrected on the first day of the following month.

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).

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 health care 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 health care coverage. Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the Plan Administrator.

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.

ARTICLE IV.

BENEFITS

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

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

A. Benefit Categories

1. **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.
2. **NON-NETWORK BENEFITS (Out-of-Network):** Benefits for medical care received from Non-Network Providers (Providers not contracted in the Network or another Blue Plan's PPO Network).

B. Deductible Amounts

1. Subject to the Deductible Amount, as shown in the Schedule of Benefits, and other terms and provisions of this Benefit Plan, the Claims Administrator will provide Benefits in accordance with the Coinsurance shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period. The following Deductibles may apply to Covered Services provided by this Benefit Plan.
 - a. **Individual Deductible Amount** – The dollar amount, as shown in the Schedule of Benefits, that a Plan Participant must pay within a Benefit Period before the Plan starts paying benefits. The Annual Deductible does not apply to Preventive and Wellness Care.
 - b. **Family Deductible Amount** – The dollar amount, as shown in the Schedule of Benefits, that Plan Participants in a class of coverage with more than one (1) Plan Participant must pay within the Benefit Period before this Plan starts paying Benefits. Once the Family Deductible Amount is met, the Individual Deductible Amount of all other Plan Participants of the family

unit will be considered satisfied for that Benefit Plan, and this Plan starts paying Benefits for all Plan Participants of the family unit. For purposes of this Benefit Plan, "family" includes all Available Classes of Coverage, except single Plan Participant or Employee Only coverage.

- c. If this Plan includes more than one (1) Plan Participant, the Individual Benefit Period Deductible Amount is not applicable and only the Family Benefit Period Deductible Amount applies. No Benefits are eligible for payment on any Plan Participant of the family until the total Family Benefit Period Deductible Amount has been satisfied.
 - d. The Plan will apply the Plan Participant's Eligible Expenses to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by the Claims Administrator. The Claims Administrator's records will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays his Deductible Amount, the Plan Participant is entitled to receive a refund from the Provider in which the overpayment was made.
2. If the Plan pays the Provider amounts that are the Plan Participant's responsibility, such as Deductibles or Coinsurance, the Claims Administrator may collect such amounts directly from the Plan Participant. The Plan Participant agrees that the Claims Administrator has the right to collect such amounts.

C. Coinsurance

If a Coinsurance is shown on the Schedule of Benefits for a Covered Service, the Plan Participant must first pay any applicable Deductible Amount before the Coinsurance. After any applicable Deductible Amount has been met, the Claims Administrator will provide payment based on the Coinsurance shown in the Schedule of Benefits toward Allowable Charges for Covered Services. The Claims Administrator's actual payment to a Provider or payment to the Plan Participant satisfies the Plan's obligation to provide Benefits under this Benefit Plan.

D. Out-of-Pocket Maximum

1. After the Plan Participant has met the Individual Out-of-Pocket Maximum, as shown in the Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Allowable Charge for Covered Services for the remainder of the Benefit Period.
2. If this Benefit Plan includes more than one (1) Plan Participant, the Individual Out-of-Pocket Maximum is not applicable and only the Family Out-of-Pocket Maximum applies. After the Family Out-of-Pocket Maximum has been met, as shown in the Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Allowable Charge for Covered Services for all covered family Plan Participants for the remainder of the Benefit Period.
3. The following apply toward the Out-of-Pocket Maximum:
 - a. Deductibles;
 - b. Coinsurance; and
 - c. Copayments.

4. The following do not apply toward the Out-of-Pocket Maximum:
 - 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.
5. Eligible Expenses for services of a Network Provider that are applied to the Out-of-Pocket Maximum for Network Providers will not apply toward the Out-of-Pocket Maximum for Non-Network Providers.

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

When the Out-of-Pocket Maximum, 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

Plan Participants' needs sometimes require that they transfer from one of the Group's Plans to another. 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 Maximums, 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 Abuse Admissions) must be Authorized as outlined in the Care Management Article. 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 in the Schedule of Benefits. The following services furnished to a Plan Participant by a Hospital are covered:

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

A. Inpatient Bed, Board and General Nursing Service

1. In a Hospital.
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 in the Schedule of Benefits.
4. In a Residential Treatment Center for Plan Participants with a Mental Health or Substance Abuse Benefits.

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 Procedure

- (1) The primary or major procedure will be the procedure with the greatest value based on the Allowable Charge.
- (2) Benefits for the primary procedure will be based on the Allowable Charge.

b. Secondary Procedure(s)

The secondary procedure(s) is a procedure(s) performed in addition to the primary procedure, which adds significant time, risk, or complexity to the Surgery. The Allowable Charge for the secondary procedure will be based on a percentage of the Allowable Charge that would be applied had the secondary procedure been the primary procedure.

c. Incidental Procedure

- (1) An incidental procedure is one carried out at the same time as a more complex primary procedure and which requires little additional Physician resources and/or is clinically integral to the performance of the primary procedure.
- (2) The Allowable Charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

d. Unbundled Procedure(s)

- (1) Unbundling occurs when two (2) or more procedure codes are used to describe Surgery performed when a single, more comprehensive procedure code exists that accurately describes the entire Surgery performed. The unbundled procedures will be rebundled for assignment of the proper comprehensive procedure code as determined by Claims Administrator.
- (2) The Allowable Charge includes the rebundled procedure. The Plan will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as determined by the Claims Administrator.

e. Mutually Exclusive Procedure(s)

- (1) Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made.
- (2) The Allowable Charge includes all procedures performed at the same surgical setting. Procedure(s), 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 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. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies;
5. Medical and surgical supplies, casts, and splints;
6. Diagnostic testing, including, but not limited to, laboratory examinations and x-ray Services rendered by a Hospital employee;
7. Surgical and medical supplies billed for treatment received in a Hospital or Ambulatory Surgical Center;
8. Physical Therapy provided by a Hospital employee; and
9. 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 in the Schedule of Benefits.

A. Surgical Services

1. Surgery

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

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 Procedure

- (1) The primary or major procedure will be the procedure with the greatest value based on the Allowable Charge.
- (2) Benefit Payment for the primary procedure will be based on the Allowable Charge.

b. Secondary Procedure(s)

The secondary procedure(s) is a procedure(s) performed in addition to the primary procedure, which adds significant time, risk, or complexity to the Surgery. The Allowable Charge for the secondary procedure will be based on a percentage of the Allowable Charge that would be applied had the secondary procedure been the primary procedure.

c. Incidental Procedure

- (1) An incidental procedure is one carried out at the same time as a more complex primary procedure and which requires little additional Physician resources and/or is clinically integral to the performance of the primary procedure.

- (2) The Allowable Charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.
- d. Unbundled Procedure(s)
 - (1) Unbundling occurs when two (2) or more procedure codes are used to describe Surgery performed when a single, more comprehensive procedure code exists that accurately describes the entire Surgery performed. The unbundled procedures will be rebundled for assignment of the proper comprehensive procedure code as determined by Claims Administrator.
 - (2) The Allowable Charge includes the rebundled procedure. The Plan will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as determined by Claims Administrator.
- e. Mutually Exclusive Procedure(s)
 - (1) Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made.
 - (2) The Allowable Charge includes all procedures performed at the same surgical setting. Procedure(s), which are not considered Medically Necessary, will not be covered.

3. Assistant Surgeon

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

4. Anesthesia

- a. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services.

Coverage is also provided for other forms of anesthesia services as defined and approved by the Plan. 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 will be provided for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. Second or third opinion consultant must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory in order to receive Benefits.

B. Inpatient Medical Services

Subject to provisions in the sections for Surgery and Pregnancy Care 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

Blue Cross and Blue Shield of Louisiana does not provide claims payment services for drugs purchased at a pharmacy. These drugs and others are payable under the Pharmacy Benefits that are provided by OGB's Pharmacy Benefit Manager. See the Schedule of Benefits for more information.

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 the coverage. If a Plan Participant receives Preventive or Wellness Covered Services from a Network Provider, the Covered Services will be paid at one hundred percent (100%) of the Allowable Charge. When Preventive or Wellness Care Covered Services are rendered by a Non-Network Provider, the Benefits will be subject to Deductible Amounts and Coinsurance, as shown in the Schedule of Benefits. The Deductible Amount will apply to Covered Services received from a Non-Network Provider, unless otherwise stated below. Preventive or Wellness Care services may be subject to other limitations shown in the Schedule of Benefits.

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

1. Visits to an obstetrician/gynecologist for recommended covered Preventive or Wellness Care services. Additional visits recommended by the Plan Participant's obstetrician/gynecologist for services other than covered Prevention or Wellness Care may be subject to the Deductible Amount or Coinsurance percentage shown in the Schedule of Benefits.
 - a. One (1) routine Pap smear per Benefit Period.
 - b. One (1) mammography examination per Benefit Period. Additional mammography examinations recommended by the Plan Participant's Physician may be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.

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 services such as an MRI, MRA, CT scan, PET scan, nuclear cardiology and endoscopy are not covered under this Preventive or Wellness Care Benefit. These high tech 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 occult blood test, flexible sigmoidoscopy, or routine 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. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational.

Physician prescribed colonoscopy preparations and supplies for routine colonoscopies covered under the Preventive and Wellness Benefit will be covered at no cost to the Plan Participant when obtained from a Network Pharmacy.

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.

6. One (1) osteoporosis screening, per Benefit Period, is available at no cost to the Plan Participant, for women age 60 and older, when care is received from a Network Provider.

C. Immunizations (Benefit Period Deductible does not apply)

1. 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

Services recommended by the U.S. Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

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 U.S. Department of Health and Human Services' website at: <http://www.healthcare.gov/prevention/index.html> or contact Our Customer Service Department at the telephone number on Your ID card.

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 BENEFITS

- A. Treatment of Mental Disorders is covered. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treatment of Mental Disorders do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
- B. Inpatient and Intermediate Care treatment in a Hospital or Alternate Care Facility for Mental Health must be Authorized as provided in the "Care Management" Article of this Benefit Plan.
- C. Mental Health services are subject to the Deductible and Coinsurance, as shown on the Schedule of Benefits.
- D. Benefits for Mental Health Services include:
 1. Mental Health evaluations and assessment
 2. Diagnosis
 3. Treatment planning
 4. Referral services
 5. Medication management
 6. Inpatient services
 7. Partial hospitalization/day treatment
 8. Intensive outpatient treatment
 9. Residential Treatment Facility

10. Individual, family and group therapeutic services

11. Crisis intervention

ARTICLE X.

SUBSTANCE ABUSE BENEFITS

- A. Benefits for treatment of Substance Abuse are available. Covered Services are limited to those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.
- B. Inpatient and Intermediate Care treatment in a Hospital or Alternate Care Facility for Substance Abuse must be Authorized as provided in the "Care Management" Article of this Benefit Plan.
- C. Substance Abuse services are subject to the Deductible and Coinsurance, as shown on the Schedule of Benefits.
- D. Benefits for Substance Abuse Services include:
 - 1. Substance Abuse and chemical dependency evaluations and assessment
 - 2. Diagnosis
 - 3. Treatment planning
 - 4. Referral services
 - 5. Medication management
 - 6. Inpatient services
 - 7. Partial hospitalization/day treatment
 - 8. Intensive outpatient treatment
 - 9. Residential Treatment Facility
 - 10. Individual, family and group therapeutic services
 - 11. Crisis intervention

ARTICLE XI.

ORAL SURGERY AND DENTAL SERVICES

A. Oral Surgery

- 1. Impacted Teeth

Eligible Expenses incurred in connection with the removal of impacted teeth, including preoperative and post-operative care, anesthesia, radiology, and pathology services, and facility charges are subject to the Deductible and Coinsurance.

B. Dental Services

- 1. Benefits are available for dental services not otherwise covered by this Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth.

2. Accidental Injury

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 three (3) months of the accidental injury and be completed within twelve (12) months after the date of injury.

Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident." Benefits are not available for repairs to teeth that are injured as a result of such activities.

The Plan Participant must notify the Claims Administrator as soon as possible before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. If authorization is not requested prior to services being rendered, Benefits otherwise payable will be reduced to 50% of Eligible Expenses.

C. Anesthesia Services

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

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 Plan Participant's ID card for a copy of the directory.

ARTICLE XII. 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's 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's. 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's will forward written Authorization to the Plan Participant and to the Provider(s).

A. Acquisition Expenses

Except for bone marrow transplants, donor costs are not payable under this Benefit Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for Bone Marrow transplant procedures will include costs associated with the donor- patient to the same extent and limitations associated with the Covered Person, except the reasonable costs of searching for the donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

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

B. Organ, Tissue and Bone Marrow Transplant Benefits

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

To locate a BDCT or BCBSLA Network Provider facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their 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).

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:

C. Solid Human Organ Transplants of the:

1. liver;
2. heart;
3. lung;
4. heart/lung;
5. kidney;
6. pancreas;
7. kidney/pancreas;
8. small bowel;
9. liver/small bowel; and
10. 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.

D. 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. If an Inpatient Admission is required, it is subject to the Article on Care Management.

These following tissue transplants are covered:

1. blood transfusions;
2. autologous parathyroid transplants;
3. corneal transplants;

3. bone and cartilage grafting;
4. skin grafting;
5. autologous islet cell transplants; and
6. 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.

E. 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 XIII. 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 wife of an Employee whose coverage is in effect at the time such services are furnished in connection with her pregnancy.

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 child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a caesarean 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.

We have several maternity programs available to help pregnant Plan Participants deliver healthy babies. Please call Our Customer Service Department at the number on the back of Your ID card when You learn You are having a baby. When You call, We'll let You know what programs are 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. Surgical and Medical Services
 - a. Initial office visit and visits during the term of the pregnancy.

- b. Diagnostic Services.
 - c. Delivery, including necessary pre-natal and post-natal care.
2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for well-baby care is included in the mother's Eligible Expenses for the covered portion of her Admission for Pregnancy Care.
 3. Elective deliveries prior to the thirty-ninth (39th) week of gestation are not covered unless shown to be Medically Necessary. Facility and other charges associated with an elective early delivery that is not Medically Necessary are also considered to be non-covered.
 4. 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.

When a child is born to a policy having Subscriber only coverage, the child is granted 30 days of automatic coverage on the policy from the date of birth and the Deductible will increase from an Individual Deductible to a Family Deductible. The Claim for the delivery charges may be applied to the new Family Deductible.

B. Care for a Newborn When Covered at Birth as a Dependent

1. Surgical and medical services rendered by a Physician, for treatment of illness, prematurity, post-maturity, or congenital condition of a newborn and circumcision. 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, or congenital condition of a newborn. Charges for well newborn care which are billed separately from the mother's Hospital bill are not covered. The Hospital (nursery) charge for well newborn is included in the mother's Hospital bill for the covered portion of her Admission for Pregnancy Care.
3. 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.

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

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

Also, under federal law, Plans may not set the level of Benefits or Out-of-Pocket costs so that any later portion of the forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or Newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other health care Provider obtain Authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours. However, to use certain Providers or facilities, or to reduce Your Out-of-Pocket costs, You

may be required to obtain Authorization. For information on Authorization, contact the Claims Administrator.

ARTICLE XIV. REHABILITATIVE CARE BENEFITS

Rehabilitative Care Benefits will be available for services provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, Pulmonary Therapy and/or Chiropractic Services. Benefits are available when services are rendered by a Provider licensed and practicing within the scope of his license. The Plan Participant must be able to tolerate a minimum of three (3) hours of active Occupational, Physical, or Speech/Language Pathology Therapy per day. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the Plan Participant's condition within two (2) months of the start of treatment.

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.

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.

Benefits for these services may be subject to any limitation or maximum Benefits if shown in 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 health care Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the health care 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 in 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, cognitive-communication or swallowing function.
3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to receiving of services.

D. Pulmonary Therapy

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

E. 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.
4. Benefits are limited to one (1) visit and one (1) treatment per day.

ARTICLE XV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. Ambulance Service Benefits

1. Ground Ambulance Transport Services

a. Emergency Transport

Benefits are available for Ambulance Services for local transportation for Emergency Medical Conditions or Medically Necessary Inpatient Hospital services only as follows:

- (1) for Plan Participant, to or from the nearest Hospital that can provide 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 will be available for Ambulance Services for local transportation of Plan Participants for non-emergency conditions to obtain medically necessary diagnostic or therapeutic Outpatient services (e.g., MRI, CT scan, dialysis, wound care, etc.), when the Plan Participant is bed-confined or his condition is such that the use of any other method of transportation is contraindicated.

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

- (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 Emergency Medical Conditions or when the Plan Participant is in a location that cannot be reached by ground ambulance. 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.

b. Non-Emergency Transport

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

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

B. Attention Deficit/Hyperactivity Disorder

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

C. Autism Spectrum Disorders (ASD)

ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Plan Participants under age twenty-one (21) are eligible for Applied Behavior Analysis when the Claim Administrator determines it is Medically Necessary. Applied Behavior Analysis is not covered for Plan Participants age twenty-one (21) and older.

ASD Benefits are subject to the Deductibles, and Coinsurance amounts that are applicable to the Covered Services obtained. (Example: A Plan Participant obtains speech therapy for treatment of ASD. Plan Participant will pay the applicable Deductible or Coinsurance amount shown on the Schedule of Benefits for speech therapy.)

D. Bone Mass Measurement

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

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

Deductible and/or Coinsurance amounts are applicable.

E. Breast Reconstructive Surgery Services

1. A Plan Participant who is receiving Covered Services in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy will also receive Benefits for the following Covered Services:
 - a. reconstruction of the breast on which the mastectomy has been performed;
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.
2. 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 Deductible and Coinsurance.

F. Other Reconstructive Procedures

Benefits are available for services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness, or Congenital Anomaly.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures.

G. Cleft Lip and Cleft Palate Services

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

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

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

H. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other life-threatening disease or condition. Coverage will be subject to any

applicable terms, conditions and limitations that apply under this Benefit Plan, including Deductible, or Coinsurance amounts shown in 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 disease or condition;
 - b. And either,
 - i. The referring health care 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
 - ii. The Plan Participant provides medical and scientific information establishing that the Plan Participant's participation in such trial would be appropriate based upon the Plan Participant meeting the conditions described in paragraph a, above.
3. An "Approved Clinical Trial" for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that:
 - a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - i. The National Institutes of Health.
 - ii. The Centers for Disease Control and Prevention.
 - iii. The Agency for Health Care Research and Quality.
 - iv. The Centers for Medicare & Medicaid Services.
 - v. Cooperative group or center of any of the entities described in paragraphs (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
 - vi. 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 U.S. 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:
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. Department of Energy.

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

I. Diabetes Education and Training for Self-Management

1. 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 Physician.
2. Evaluation and training programs for diabetes self-management is covered subject to the following:
 - a. The program must be determined to be Medically Necessary by a Physician and provided by a licensed health care professional who certifies that the Plan Participant has successfully completed the training program.
 - b. The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.
3. Benefits are not available for Diabetes Education and Training for Self-Management services rendered by a Non-Network Provider.

J. 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 for outpatient use 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;
- (4) it is appropriate for use in the patient's home; and
- (5) it is not consumable or disposable.

b. Examples include, but are not limited to the following:

- (1) Equipment to assist with mobility, such as a standard wheelchair;
- (2) A standard hospital bed;
- (3) Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks);
- (4) Delivery pumps for tube feedings (including tubing and connectors);
- (5) Braces, including necessary adjustments to shoes to accommodate braces; and
- (6) Braces that stabilize an injured body part and braces to treat curvature of the spine;
- (7) Mechanical equipment necessary for the treatment of chronic or acute respiratory failure.

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

- (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge).
- (2) At the Plan's option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, oxygen and oxygen equipment required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.
- (3) Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Plan Participant selects deluxe equipment solely for his comfort or convenience.
- (4) Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.

- (5) 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.
 - (6) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Benefits are available for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every Plan Year. Replacement of equipment lost or damaged due to neglect or misuse or for replacement of equipment within five (5) years of purchase or rental will not be covered.
- d. 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 repair or replacement of equipment lost or damaged due to neglect or misuse.
 - (4) 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.

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. The Plan will determine this time period.
- c. Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when a Plan Participant selects a deluxe device solely for his comfort or convenience.
- d. Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented to be Medically Necessary.
- e. No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

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

- a. Coverage is limited to artificial eyes, ears and noses.
- b. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.
- c. 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. The Plan will determine this time period.
- d. Mastectomy bras are limited to 2 (two) per Plan Year.
- e. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience.
- f. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.

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

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

- a. Benefits are limited to artificial arms, legs, feet and hands.
- 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. The Plan will determine this time period.
- c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience. A Plan Participant may choose a Prosthetic Appliance or Device that is priced higher than the benefit payable under this Plan and may pay the difference between the price of the device and the benefit payable, without financial or contractual penalty to the Provider of the device.
- d. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.
- e. 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).

K. Hearing Aids

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 hearing aid, per ear, in a thirty-six (36) month period. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

The Plan will pay up to the Allowable Charge for this Benefit. The Plan may increase the Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge.

Eligible implantable bone conduction hearing aids are covered the same as any other service or supply, subject to any applicable Coinsurance and Deductible amounts.

L. Hospice and Home Health Care

1. Hospice Care is covered when recommended by a Physician and may be limited if shown in the Schedule of Benefits.
2. Benefits are available for Hospice Care when provided by a licensed Hospice agency.
3. Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered, and may be limited as shown in the Schedule of Benefits.
4. 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.
5. 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 is delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;
 - d. it requires clinical training in order to be delivered safely and effectively;
 - e. it is not custodial.

Prior Authorization is required for Home Health and Hospice services. If Prior Authorization is not obtained, Benefits otherwise payable will be reduced by fifty percent (50%).

M. 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

N. Lymphedema Benefit

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

O. Permanent Sterilization Procedures

Benefits are available for surgical procedures that result in permanent sterilization, including vasectomy and hysteroscopic placement of micro-inserts into the fallopian tubes. Tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes are available as a Preventive or Wellness Care Benefit.

P. 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.

Q. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Only sleep studies performed in the home or sleep studies performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM) are eligible for coverage.

ARTICLE XVI.

CARE MANAGEMENT

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

1. Selection of Provider

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

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

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

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

If the services were Medically Necessary, Benefits will be provided based on the 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.

The Plan Participant remains responsible for any applicable Copayment or Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

- (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 Copayment or Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

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

b. Outpatient Services, Other Covered Services and Supplies

- (1) If a Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

- (2) If Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable. 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 his applicable Copayment, Deductible and Coinsurance percentage.

- (3) If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the amount shown in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization. The Plan Participant is responsible for all charges not covered and remains responsible for his Copayment, Deductible and applicable Coinsurance percentage.

3. Authorization of Admissions

a. Authorization of Elective Admissions

The Plan Participant is responsible for ensuring that his Provider notifies the Claims Administrator's Care Management Department of any Elective or non-emergency Inpatient Hospital Admission. The Claims Administrator must be notified (by calling the telephone number shown in the Schedule of Benefits or the Plan Participant's ID card) prior to the Admission regarding the nature and purpose of any Elective Admission or non-emergency

Admission to a Hospital's Inpatient department. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Claims Administrator when the Hospital Inpatient setting is documented to be Medically Necessary.

- (1) If a request for Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission is not covered and the Plan Participant must pay all charges incurred during the Admission for which Authorization was denied.
- (2) If Authorization is not requested prior to an Admission, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the 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 apply toward satisfying the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

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

- (1) If Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission will not be covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission for which Authorization was denied.
- (2) If Authorization is not requested, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the 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 apply toward the Out-of-Pocket Amount.

c. Concurrent Review

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

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

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

- a. If a request for Authorization is denied by the Claims Administrator, the Outpatient services and supplies are not covered.
 - b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, the Plan will have the right to determine if the services and supplies were Medically Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the 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 apply toward satisfying the Out-of-Pocket Amount.
5. Appeals
- a. If either the Plan Participant or the Provider disagrees with the denial of any Authorization, the denial may be appealed as shown in the Complaints, Grievance and Appeals article of this Benefit Plan. The Plan Participant or the Provider may Appeal the denial by contacting the Claims Administrator in writing within one hundred eighty (180) days of notice of the denial in accordance with the Complaints, Grievance and Appeals article of this Benefit Plan.
 - b. If the Claims Administrator does not reverse the decision, the Plan Participant will be responsible for (and no Benefits will be payable for) charges incurred.
 - c. Providers will be notified of Appeal results only if the Provider filed the Appeal.

B. Live Better Louisiana Wellness Program

OGB, in partnership with the BCBSLA, offers an integrated health promotion program aimed at improving quality of care and lowering overall medical costs.

1. Worksite Wellness - Catapult

The Worksite Wellness program provides onsite preventive health visits and consultation with a certified Nurse Practitioner. The visit may include a personal health history, lab tests, blood pressure, waist measurement and BMI. Participants receive a personal health report and action plan, which may include referral(s) to other health promotion programs.

The Worksite Wellness program is available to Employees and Retirees with and without Medicare who are enrolled as the primary policyholder in a Blue Cross and Blue Shield of Louisiana health plan. Spouses and Dependents are not eligible at this time.

2. Prevent Diabetes Prevention Program (DPP)

Prevent is a lifestyle management program designed to help participants, who have been identified as pre-diabetic, reduce the risk of developing diabetes. A personal health coach provides one-on-one guidance for diet, activity and healthy lifestyle choices.

Prevent is available to Employees and Retirees without Medicare who are enrolled as the primary policyholder in a Blue Cross and Blue Shield of Louisiana health plan. Spouses, Dependents and Retirees with Medicare are not eligible at this time.

C. 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 of these five (5) chronic health conditions – diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD).

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 five 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 maintain a continuing relationship with the BCBSLA health coach that includes a telephone call at least once every three months.

D. 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 Abuse 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.

E. 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 Article 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.

ARTICLE XVII.

LIMITATIONS AND EXCLUSIONS

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, the following, and complications from the following, are not covered REGARDLESS OF ANY CLAIM OF MEDICAL NECESSITY:

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. Administrative fees, interest, penalties, or sales tax.
3. 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.

4. Diagnostic or treatment measures that are not recognized as generally accepted medical practice.
5. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or required by law.
6. Services rendered by a Physician or other healthcare Provider 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 health care 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. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. 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.
12. Any charges exceeding the Allowable Charge.
13. 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 for such determinations;
14. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services, except as specifically provided in this Benefit Plan.
15. Charges for the delivery of health care, diagnosis, consultation, or treatment of a Member, unless the Provider is physically present with the Member at the time services are rendered, are not covered unless approved by the Claims Administrator. Charges for the delivery of health care, diagnosis, consultation, or treatment of a Member using technology, including but not limited to audio and video transmission, telephone, or email are not covered unless approved by the Claims Administrator.

16. 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.
17. Any incidental procedure, unbundled procedure or mutually exclusive procedure, except as described in this Benefit Plan.
18. No Benefits will be provided 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. lactation therapy
 - k. sensory integration therapy
19. 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 is not actively involved in the Plan Participant's care after the service is received. This exclusion does not apply to mammography testing.
20. Health services provided in a foreign country, unless required as Emergency Health Services.
21. Travel or transportation expenses, even though prescribed by a Physician. Some travel Expenses related to covered transplantation services may be reimbursed at the Plan Administrator's sole discretion.
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. 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, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charge for services, supplies or equipment advertised by the provider as free.
27. Any charges prohibited by federal anti-kickback or self-referral statuses.

B. COSMETIC

1. Services, supplies, or treatment for cosmetic purposes, including cosmetic surgery and any cosmetic 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. Services, surgery, supplies, treatment or expenses for the following REGARDLESS OF CLAIM OF MEDICAL NECESSITY:
 - 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 or reduction, except for Breast Reconstructive Surgical Services as specifically provided in this Benefit Plan;
 - e. implantation of breast implants and services; except for Breast Reconstruction Surgical Services specifically provided in this Benefit Plan;
 - f. implantation, removal and/or re-implantation of penile prosthesis and services; and
 - g. diastasis recti;
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Regardless of Medical Necessity services, Surgery, supplies, treatment or expenses related to:
 - a. weight reduction programs;
 - b. removal of excess fat or skin or services at a health spa or similar facility; or
 - c. obesity or morbid obesity.

This exclusion does not apply to Plan Participants who are enrolled in the Plan's HEADS UP! program for morbid obesity. Treatment or expenses related to complications from morbid obesity surgery are covered by the Plan for Plan Participants who are enrolled in the Plan's HEADS UP! program for morbid obesity. The exclusion for removal of excess fat or skin or services at a health spa or similar facility continues to apply to all Plan Participants.

5. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings.

This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.

6. Routine foot care; palliative or cosmetic care or treatment; treatment of flat feet, except for persons who have been diagnosed with diabetes; cutting or removal of corns and calluses; nail trimming or debriding, or supportive devices of the foot.
7. Pharmacological regimens, nutritional procedures or treatments that are primarily for cosmetic purposes;
8. 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.
9. 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.
10. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
11. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

This exclusion does not apply to Plan Participants who are enrolled in the Plan's HEADS UP! Program for morbid obesity.

12. Medical and surgical treatment of excessive sweating (hyperhidrosis).
13. 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, devices or kits to stimulate the penis, 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. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.
7. Medical and Surgical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP).
8. Alternative Treatments including the following:

- a. Acupressure and acupuncture.
 - b. Aromatherapy.
 - c. Hypnotism.
 - d. Massage therapy services when: services are not prescribed by a Physician; prior authorization is not obtained; or, services are not performed by a health care provider who is acting within the scope of his license.
 - e. Rolfing.
 - f. Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM).
9. Comfort or Convenience Items including
- a. Television.
 - b. Telephone.
 - c. Beauty/Barber service.
 - d. Guest service.

D. THIRD PARTY/PLAN PARTICIPANT RESPONSIBILITY OR FAULT

Injury compensable under any worker's compensation program, regardless of whether the patient has filed a claim for benefits. This applies to compensation provided on an expense incurred basis or blanket settlements for past and future losses.

1. 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 taking part in a riot or acts of civil disobedience;
 - c. those occurring as a result of a Plan Participant's commission or attempted commission of a felony;
 - d. for treatment of any Plan Participant confined in a prison, jail, or other penal institution; or
 - e. those occurring as a result of the Plan Participant's involvement in a hazardous activity, including but not limited to, the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing.

Health services for treatment of military service related disabilities, when the Plan Member is are 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. Eye exercise therapy.
 8. 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.
 9. Routine vision examinations, including refractive examinations.
 10. Routine eye examinations, glasses and contact lenses, except as specifically provided for in this Benefit Plan.
 11. 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.

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. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - a. Elastic stockings;
 - b. Ace bandages;
 - c. Gauze and dressings;
 - d. Ostomy supplies;
 - e. Syringes; and
 - f. Diabetic test strips.
10. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces.)
11. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.
12. Oral appliances for snoring.
13. 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 legal Spouse. Services and supplies for the treatment of and/or related to gender dysphoria.
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. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.
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. Marriage counseling, family relations counseling, divorce counseling, parental counseling, pastoral counseling, job counseling and career counseling.
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;
 - c. treatment related to sex transformations, or sexual inadequacies, except for the Diagnosis and/or treatment of sexual dysfunction/impotence;
 - d. 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;
 - e. recreational therapy; or
 - f. 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 exclusion for educational services and supplies does not apply to training and education for diabetes.
7. Sleep studies, unless performed in the home or performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM). If a sleep study is performed in a sleep laboratory that is not accredited by one of these bodies, or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.
8. Applied Behavior Analysis (ABA) that the Company has determined is not Medically Necessary. ABA rendered to Plan Participants age twenty-one (21) and older. ABA rendered by a Provider that has not been certified as a behavior analyst by the Behavior Analyst Certification Board or rendered by a Provider that has not provided, to the satisfaction of Company, documented evidence of equivalent education, professional training, and supervised experience in ABA. 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.
13. Nutritional counseling for either individuals or groups.

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); or
 - d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered.
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. Vitamins, dietary supplements and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU)).

2. Investigational drugs and drugs used other than for the FDA approved indication, 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 and all Medically Necessary services associated with the administration of the drug. These drugs may be covered by OGB's Pharmacy Benefit Administrator. Please refer to the Schedule of Benefits or call the Pharmacy Administrator at the telephone number on the back of the Plan Participant ID card.
3. 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. BEHAVIORAL HEALTH/SUBSTANCE ABUSE

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 nicotine or 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 Abuse 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. Mental Health Services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
9. 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.

10. Services provided in a Residential Treatment Center for the active treatment of specific impairments of Mental Health or substance abuse, except as specifically provided in this Benefit Plan.
11. Treatment or services for mental health and substance abuse 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 XVIII.

COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits ("COB") section applies to This Plan when a Plan Participant has health care coverage under more than one plan. "Plan" and "This Plan" as used in the Article are defined below.
2. If this COB section applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the Benefits of This Plan are determined before or after those of another plan. The Benefits of This Plan:
 - a. will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its Benefits before another plan;
 - b. may be reduced when under the Order of Benefit Determination Rules, another plan determines its Benefits first. That reduction is described in Section D. of this COB section, "Effect on the Benefits of This Plan."
3. When Benefits are available for Prescription Drugs, the Claims Administrator does not coordinate Benefits for Prescription Drug Claims, except for Claims that are subject to Medicare Part D and Medicare Secondary Payor requirements.

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

1. "Plan" means any Group, group-type, or blanket health plan which provides Benefits for services, supplies, or equipment for Hospital, surgical, medical, or dental care or treatment, including, but not limited to, coverage under:
 - a. insurance policies, non-profit health service plans, health maintenance organizations, Subscriber contracts, self-insured plans, pre-payment plans, automobile or homeowners medical payments plans, and hospital indemnity plans with respect to Benefits under these plans in excess of three-hundred (\$300.00) dollars per day;
 - b. government programs, including compulsory no-fault automobile insurance, unless an applicable law forbids coordinating Benefits with this type of program;
 - c. labor-management trustee plans, union welfare plans, employer organization plans, employee benefit organization plans, and professional association plans;
 - d. any other employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended;
 - e. Medicare as permitted by federal law;
 - f. group-type plans or policies which can be obtained only because of employment with or membership in a particular organization, corporation, or other business entity.

This does not include school accident insurance, individual or family group contracts (as defined by Louisiana law), Medicaid, hospital daily indemnity plans, specified diseases only policies, or limited occurrence policies which provide only for intensive care or coronary care in the hospital.

Each plan or other arrangement for coverage is a separate plan. If an arrangement has two (2) parts and COB rules apply only to one of the two (2), each of the parts is a separate plan.

2. "This Plan" means the part of the Group's Benefit Plan and any amendments/endorsements thereto that provides Benefits for health care expenses.
3. "Primary Plan" / "Secondary Plan." The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its Benefits are determined before those of the other plan and without considering the other plan's Benefits. When This Plan is a Secondary Plan, its Benefits are determined after those of the other plan and may be reduced because of the other plan's Benefits.

When there are more than two (2) plans covering the person, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

4. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one (1) or more plans covering the person for whom the Claim is made.
When a plan provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When Benefits are reduced under a Primary Plan because a covered person does not comply with the Primary Plan's provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Authorization of Admissions or services, and Network Provider arrangements.

5. "Claim Determination Period" means that part of the calendar year during which a person covered by This Plan is eligible to receive Benefits under the provisions of This Plan.

C. Order of Benefit Determination Rules

1. When there is a basis for a Claim under This Plan and another plan, This Plan is a Secondary Plan which has its Benefits determined after those of the other plan, unless:
 - a. the other plan has rules coordinating its Benefits with those of This Plan; and
 - b. both those rules and This Plan's rules, in paragraph 2. below, require that This Plan's Benefits be determined before those of the other plan.
2. This Plan determines its order of Benefits using the first of the following rules which applies:
 - a. Non-Dependent/Dependent: The Benefits of the plan which covers the person as an Employee (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - (1) Secondary to the plan covering the person as a Dependent, and
 - (2) Primary to the plan covering the person as other than a Dependent, then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.

- b. Dependent Child/Parents Not Separated or Divorced: Except as stated in paragraph 2(c) below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents:"
 - (1) the Benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the calendar year; but
 - (2) if both parents have the same birthday, the Benefits of the plan which covered one parent longer are determined before those of the plan, which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of Benefits, the rule in the other plan will determine the order of Benefits.

- c. Dependent Child/Separated or Divorced Parents: If two (2) or more plans cover a person who is a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:
 - (1) first, the plan of the parent with custody of the child;
 - (2) then, the plan of the spouse of the parent with custody of the child; and
 - (3) finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the plan of that parent has actual knowledge of those terms, the Benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan.

This paragraph does not apply when any Benefits are actually paid or provided before the entity has that actual knowledge.

- d. Joint Custody: If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of Benefit determination rules outlined in Section C.2.b.
- e. Active/Inactive Employee: The Benefits of a plan which covers a person as an Employee who is not terminated, laid off, or retired (or as that Employee's Dependent) are determined before those of a plan which covers that person as a terminated, laid off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- f. Continuation Coverage: If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of Benefit determination:
 - (1) first, the Benefits of a plan covering the person as an Employee or their Dependent;
 - (2) second, the Benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

- g. Longer/Shorter Length of Coverage: If none of the above rules determines the order of Benefits, the Benefits of the plan which covered an Employee or as a Dependent longer are determined before those of the plan which covered that person for the shorter time.

D. Effects on the Benefits of this Plan

1. This Section applies when, in accordance with Section C., "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the Benefits of This Plan may be reduced, as described in this section. Such other plan or plans are referred to as "the other plans" in Paragraph 2 immediately below.
2. Reduction in This Plan's Benefits

The Benefits of This Plan will be reduced when the sum of:

- a. the Benefits that would be payable for the Eligible Expenses under This Plan in the absence of this COB section, and
- b. the Benefits that would be payable for the Allowable Expenses under the other plans in the absence of provisions with a purpose like that of this COB section, whether or not Claims are made, would be more than those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of This Plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses.

When the Benefits of this Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

E. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Plan Administrator has the right to decide which facts the Claims Administrator needs. It may get needed facts from or give them to any other organization or person. The Plan Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give the Claims Administrator any facts it needs to process the Claim.

F. Facility of Payment

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

G. Right of Recovery

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

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

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

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

ARTICLE XIX. 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. Except as specifically provided herein, this Benefit Plan will not make Us liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations. To the extent that this Benefit Plan is subject to COBRA, the Plan, or its contracted designee, will be the administrator for the purposes of COBRA. The Plan is responsible for establishing and following all required COBRA procedures that may be applicable to the Plan. The Plan will indemnify and hold Us harmless in the event We incur any liability as a result of the Plan's failure to do so.
2. 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.
3. The Plan Administrator shall administer the Benefit Plan in accordance with its terms and establishes its policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Subscriber's rights, and to decide questions of plan interpretation and those of fact relating to the plan. The decisions of the Plan Administrator will be final and binding on all interested parties.
4. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, health care 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.

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

1. 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.
2. A Participant Employer shall immediately inform the Plan Administrator when a Retiree with OGB coverage returns to full-time employment. The Retiree shall be placed in the Re-employed Retiree category for premium calculation. The Re-employed Retiree premium classification applies to Retirees with and without Medicare. The premium rates applicable to the Re-employed Retiree premium classification shall be identical to the premium rates applicable to the classification for Retirees without Medicare.
3. A Participant Employer who receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the OGB MSP Adjuster within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a covered Employee. If not timely forwarded, OGB will assume responsibility only for Covered Plan benefits due to Medicare for a covered Employee. The Participant Employer will be responsible for interest, fines, and penalties due.

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 Group, the Claims Administrator will either deliver all materials to the Group for Group's distribution to the covered Employees, or the Claims Administrator will deliver the materials directly to each covered Employee.

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

E. Benefits 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.

F. 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.

G. 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.

H. Filing Claims

1. A Claim is a written or electronic proof of charges for Covered Services that a Plan Participant has incurred during the time-period he was covered under this Plan. The Plan encourages Providers to file Claims in a form acceptable to the Claims Administrator within ninety (90) days from the date services are rendered. Benefits will be denied for Claims filed any later than twelve (12) months from the date of service. Benefit Plan provisions in effect at the time the service or treatment is received shall govern the processing of any Claim filed or expense actually incurred as a result of the service or treatment 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.

I. Release of Information

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

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

J. 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.

K. 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.

L. 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).

M. 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.

N. 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 health care 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.

O. 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.

P. Out-of-Area Services

The Claims Administrator has a variety of relationships with other Blue Licensees referred to generally as "Inter-Plan Programs." Whenever Plan Participants obtain healthcare services outside of Blue Cross and Blue Shield of Louisiana's service area, the Claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

Typically, when accessing care outside Blue Cross and Blue Shield of Louisiana's service area, Plan Participants will obtain care from healthcare Providers that have a contractual agreement (i.e., are "Network Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue").

In some instances, Plan Participants may obtain care from Non-Network Providers. The Claims Administrator's payment practices in both instances are described below.

1. BlueCard® Program

Under the BlueCard® Program, when Plan Participants access covered healthcare services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating healthcare Providers.

Whenever Plan Participants access covered healthcare services outside Blue Cross and Blue Shield of Louisiana's service area and the claim is processed through the BlueCard® Program, the amount Plan Participants pay for covered healthcare services from Network Providers is calculated based on the lower of:

- a. the billed covered charges for Your covered services; or
- b. the negotiated price that the Host Blue makes available to the Plan.

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 healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Plan uses for Plan Participant’s claim because they will not be applied retroactively to Claims already paid.

2. Medicare Supplemental/Medigap/Medicare Complementary

Under Medigap/Medicare Supplemental/Medicare Complementary plans, when a Plan Participant receives treatment from a healthcare Provider that participates with the Host Blue and accepts Medicare assignment, the amount the Plan Participant pays for services otherwise covered by the federal Medicare Program will be calculated based on the Medicare allowable amount. If the healthcare Provider does not accept Medicare assignment, the Plan Participant may be liable for the difference between the amount that the Provider bills and the Medicare limiting charge, which will include the payment the Plan will make for the covered services as set forth in Group’s agreement.

If the Plan Participant has additional benefits for healthcare services which Medicare would not otherwise cover, the amount the Plan Participant pays for such services when received from a Network Provider will be calculated based on the lower of either billed covered charges or negotiated price made available to the Plan by the Host Blue.

3. Non-Network Providers outside Blue Cross and Blue Shield of Louisiana’s Service Area

When covered healthcare services are provided outside of Blue Cross and Blue Shield of Louisiana’s service area by Non-Network Providers, the amount the Plan Participant pays for such services is described below.

a. Plan Participant Liability Calculation

When covered healthcare services are provided outside of the Claims Administrator’s service area by Non-Network Providers, the amounts a Plan Participant pays for such services will generally be based on either the Host Blue’s Non-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Plan Participant may be responsible for the difference between the amount that the Non-Network Provider bills and the payment the Plan will make for the covered services as set forth in this paragraph.

b. Exceptions

In some exception cases, the Plan may pay Claims from Non-Network Providers outside of Blue Cross and Blue Shield of Louisiana’s service area based on the Provider’s billed charge, the payment the Plan would make if it were paying a Non-Network Provider inside of Blue Cross and Blue Shield of Louisiana’s service area (where the Host Blue’s corresponding payment would be more than the Blue Cross and Blue Shield of Louisiana’s in-service area

Non-Network Provider payment), or in the Claims Administrator's sole and absolute discretion, it may negotiate a payment with such a Provider on an exception basis.

In any of these exception situations, the Plan Participant may be responsible for the difference between the amount that the Non-Participating healthcare Provider bills and payment the Plan will make for the covered services as set forth in this paragraph.

c. Medigap/Medicare Supplemental/Medicare Complementary Plans

Under Medigap/Medicare Supplemental/Medicare Complementary plans, when Plan Participant receives treatment from a healthcare Provider that does not participate with the Host Blue, but does accept Medicare assignment, the amount the Plan Participant pays for services otherwise covered by the federal Medicare Program will be calculated based on the Medicare allowable amount. If the Provider does not accept Medicare assignment, the Plan Participant may be liable for the difference between the amount that the provider bills and the Medicare limiting charge, which will include the payment the Plan will make for the Covered Services as set forth in this paragraph. If the Plan Participant has additional benefits for healthcare services which Medicare would not otherwise cover, the amount the Plan Participant pays for such services provided by a healthcare Provider not participating with the Host Blue will be calculated based on either the Host Blue's Non-Network Provider local payment or the pricing arrangements required by applicable state law.

In these situations, the Plan Participant may be liable for the difference between the amount that the Non-Network Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

4. Out-of-Area Claims: Non-Network Providers Plan Participant Liability Calculation – Emergency Care

If You need Emergency Medical Services in the emergency department of a Hospital, We will cover You at the level required by the Patient Protection and Affordable Care Act and federal regulations require. You will have to pay for any charges that exceed the Allowable Charge as well as any Deductibles and Coinsurance.

Q. HIPAA Certificates of Creditable Coverage

The Plan Administrator shall provide to Plan Participants, free of charge, a written certification of their coverage under this Benefit Plan (HIPAA Certificate of Creditable Coverage) under the following circumstances:

1. The Plan Administrator will automatically issue a HIPAA Certificate of Creditable Coverage to:
 - a. an individual who is a qualified beneficiary entitled to COBRA continuation of coverage;
 - b. an individual ceasing to be covered under this Benefit Plan; and
 - c. an individual who is a qualified beneficiary and has elected COBRA continuation of coverage that has ended.
2. The Plan Administrator will issue a HIPAA Certificate of Creditable Coverage, upon request, up to twenty-four (24) months after coverage ceases.
3. To receive written guidelines on requesting and receiving a HIPAA Certificate of Creditable Coverage, the Plan Participant should contact the Plan Administrator's customer service department.

R. 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 Plan 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.

S. 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 health care operations. The terms "payment" and "health care 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 health care. "Health Care Operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care 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.

- 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
 - (4) documenting the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Plan Administrator

The Plan Administrator 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 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 Plan Administrator;
- 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 Plan Participant of the Plan Administrator's workforce, as required by Section 164.504 (f) (2) (iii) of the Privacy Standards.

The following State of Louisiana, Office of Group Benefits workforce members are authorized to receive Protected Health Information in order to perform the following duties:

- Customer Service
- Agency Services
- Eligibility Services
- Executive Staff Services
- Contract Management Services
- IT Services
- Legal Services
- Medical Director Consultation Services
- Payment Services

T. 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.

ARTICLE XX.

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 26 dependents. All other eligibility appeals 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 26 dependents shall be subject to the procedures set forth in Section C below.

Pharmacy Benefit Manager Appeals Process

Pharmacy Benefit Manager appeals information is available by calling MedImpact's Customer Contact Center at 800.788.2949 or by going to www.groupbenefits.org. Upon your written request, OGB will provide you a copy of the Pharmacy Benefit Manager appeals information at no charge.

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 the quality of care or services received from the Claims Administrator or a Network Provider. For example, services, access, availability, or attitude of the Claims Administrator or a Network Provider.

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 his 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
Claims Administrator
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

The Claims Administrator's customer service department will assist the Plan Participant or his 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 telephone request from the Plan Participant's Provider 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 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.

DUPLICATE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED.

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 determination and who are not a subordinate to any previous adverse decision-maker. When the Appeal requires medical judgment, the review will involve a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Administrative Appeals

Administrative Appeals involve coverage decisions that do not require medical judgment. Examples include a denial or partial denial of benefits (adverse benefit determinations) based on the Benefit Plan limitations or exclusions, and rescissions of coverage. Administrative Appeals should be submitted in writing to:

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

1. First Level Internal

If the Plan Participant is not satisfied with the Claims Administrator's initial decision, the Plan Participant or his Authorized Representative has **one hundred eighty (180) calendar days** from receipt of the notice of an adverse benefit determination to file a first level Appeal.

Request submitted after one hundred eighty (180) days of the denial will not be considered. If the Claims Administrator grants the first level Appeal, the Claims Administrator will reprocess the Claim.

If the Claims Administrator denies the first level Appeal, the Claims Administrator will notify the Plan Participant or his Authorized Representative, in writing, of the decision and the right to file a second level Appeal. The Claims Administrator will mail this notification within thirty (30) calendar days from the date the Claims Administrator received the first level Appeal, or as allowed by law. 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 file a second level Appeal.

2. Second Level Internal

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 **sixty (60) calendar days** from receipt of the notice denying the first level Appeal to file a second level Appeal. Request submitted after sixty (60) days of the denial will not be considered.

An Appeals Committee not involved in any previous denial will review all second level appeals. The Committee's decision will be mailed to the Plan Participant within five (5) days of the Committee meeting.

If the Claims Administrator grants the second level Appeal, the Claims Administrator will reprocess the Claim.

If the Claims Administrator denies the second level Appeal, the Claims Administrator will notify the Plan Participant or his Authorized Representative, in writing, of the decision. The Claims Administrator will mail this notification within thirty (30) calendar days from the date the Claims Administrator received the second level Appeal, or as allowed by law.

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. The Plan Participant or his Authorized Representative is entitled to receive free of charge, copies of all information relevant to the Appeal from the Claims Administrator (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 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

Medical Appeals involve a denial or partial denial of benefits based on medical judgment determinations including medical necessity, appropriateness of care (health care setting, level of care, care effectiveness), or experimental or investigational treatment. Medical Appeals should be submitted in writing to:

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

1. First Level Internal Medical Appeals

If the Plan Participant is not satisfied with the Claims Administrator's initial decision, the Plan Participant, their authorized representative, or a Provider acting on their behalf, must submit a written request to Appeal within **one hundred eighty (180) calendar days** following the Plan Participant's receipt of an initial adverse Benefit Determination.

Requests submitted after one hundred eighty (180) calendar days of the denial will not be considered. If the Claims Administrator grants the first level Appeal, the Claims Administrator will reprocess the Claim.

If the Claims Administrator denies the first level Appeal, the Claims Administrator will notify the Plan Participant or his Authorized Representative, in writing, of the decision and the right to file a second level Appeal. The Claims Administrator will mail this notification within thirty (30) calendar days from the date the Claims Administrator received the first level Appeal, or as allowed by law.

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. External Review – Second Level Medical and Rescission of Coverage Appeals

If the Plan Participant is not satisfied with a Medical or rescission of coverage Appeals decision, the Plan Participant or his Authorized Representative has **one hundred twenty (120) calendar days** from receipt of the first level decision to request an external appeal conducted by an Independent Review Organization (IRO).

To request an external review related to a Medical Appeal or a Rescission of Coverage Appeal, the request should be submitted in writing to:

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

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 review. The IRO will notify the Plan Participant or his Authorized Representative, and the Claims Administrator, in writing, of the decision within forty-five (45) calendar days from the date the IRO received the external review request from the Claims Administrator.

Expedited Appeals Process

The Expedited Appeal process is a process to review adverse Benefit determinations when the time frame of the appeal process described above would seriously jeopardize the Plan Participant's life, health, and ability to regain maximum function; or, when, in the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a decision through the appeal process described above.

For example, a request concerning an admission, availability of care, continued stay, or health care service for a Plan Participant who is requesting Emergency services, has received Emergency services but has not been discharged from a facility, or has been admitted to the facility. To request an expedited appeal, contact:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal – Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022
1-800-392-4089

1. First Level Expedited Appeal

A first level Expedited Appeal may be initiated orally or in writing by the Plan Participant or his Authorized Representative, or the Provider acting on behalf of the Plan Participant.

The Claims Administrator will make a decision within seventy-two (72) hours after receipt of the Expedited Appeal.

If the first level Expedited Appeal is denied, the Plan Participant or his Authorized Representative, or the Provider acting on behalf of the Plan Participant may file a second level Expedited Appeal for immediate review by an Independent Review Organization (IRO).

2. Second Level Expedited Appeal

A second level Expedited Appeal may be initiated orally or in writing by the Plan Participant or his Authorized Representative, or the Provider acting on behalf of the Plan Participant.

The Claims Administrator will provide the IRO all pertinent information necessary to conduct the review. The IRO will notify the Plan Participant or his Authorized Representative, or the Provider acting on behalf of the Plan Participant, and the Claims Administrator of the decision within seventy-two (72) hours from receipt of the second level Expedited Appeal from the Claims Administrator.

D. 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 Benefits 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 process.

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

E. Legal Limitations

A Plan Participant must exhaust his administrative remedies before filing a legal action. No legal action shall be brought against the Plan to attempt to recover benefits under this Plan more than one year after the time a 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.

ARTICLE XXI. HOW TO OBTAIN CARE WHILE TRAVELING, MAKE PLAN CHANGES AND FILE 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 at P. O. Box 98029, Baton Rouge, LA70898-9029, 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 health care 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 the Claims Administrator.

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States (out of country) are covered at the In-Network benefit level. Non-emergency services received outside of the United States (out of country) ARE COVERED AT THE OUT-OF-NETWORK BENEFIT LEVEL.

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 Member 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. Member 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 Member 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. Emergency Room or Outpatient Department Claims

The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility. However, in some instances involving emergencies or outpatient treatment, the 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. 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. 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.

4. 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.

5. Mental Health and/or Substance Abuse Claims

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

6. 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. If Plan Participant Has a Question About His Claim

If a Plan Participant has a question about the payment of a Claim, the Plan Participant can write to the Claims Administrator at the address below or the Plan Participant may call the Claims Administrator's customer service department at the telephone number shown on his ID card or any of the Claims Administrator's local service offices*. If the Plan Participant calls for information about a Claim, the Claims Administrator can help the Plan Participant better if the Plan Participant has the information at hand, particularly the Member ID number, patient's name and date of service.

Blue Cross and Blue Shield of Louisiana
5525 Reitz Avenue
P.O. Box 98027
Baton Rouge, LA 70898-9029

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

* Blue Cross and Blue Shield of Louisiana has local service offices located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

ARTICLE XXII. RESPONSIBILITIES OF PLAN ADMINISTRATION

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 Plan Administrator.

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
(225) 925-6625 or (225) 925-6770 (TDD)
(800) 272-8451 or (800) 259-6771 (TDD)

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 (BCBSLA)
5525 Reitz Avenue
Baton Rouge, LA 70809
(800)392-4089

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

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 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 health plans offered through the Office of Group Benefits, namely the HMO Plan, the PPO Plan, and the CDHP-HSA Plan administered by Blue Cross and Blue Shield of Louisiana (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 Group 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. In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" (you may obtain a copy of this form from the Office of Group Benefits at no charge, or you can download the form at www.groupbenefits.org), and you must follow the notice 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 to the Office of Group Benefits during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

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. 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 Office of Group Benefits 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 Office of Group Benefits 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 reduction 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 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 Office of Group Benefits in writing proof of total disability before the initial 18-month COBRA coverage period ends.

You must also provide this notice 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 Office of Group Benefits at no charge, or you can download the form at www.groupbenefits.org), 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 Office of Group Benefits during the 60-day notice period and within 18 months after the employee's termination of employment or reduction of hours, THEN 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 Office of Group Benefits. 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 Office of Group Benefits 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 Plan's form, entitled "Notice of Second Qualifying Event Form," (you may obtain a copy of this form from the Office of Group Benefits at no charge, or you can download the form at www.groupbenefits.org), **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 Office of Group Benefits within the 60-day notice period, THEN 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 special enrollment, or on the first day of the following plan year if the child is enrolled through open 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. When key parts of the Affordable Care Act take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and Out-of-Pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Office of Group Benefits informed of any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Office of Group Benefits.

Plan Contact Information

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

**Office of Group Benefits
Eligibility Department
Post Office Box 66678
Baton Rouge, Louisiana 70804
225.922.2321
225.925.6333 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 Office of Group Benefits without charge or download them at www.groupbenefits.org). 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:

**Office of Group Benefits
Eligibility Department
Post Office Box 44036
Baton Rouge, Louisiana 70804
225.922.2321
225.925.6333 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.

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.

Notice Procedures (continued)

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.