



Office of Group Benefits
Magnolia Local Plus Health Plan
For
State of Louisiana Plan Participants

provided by



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



NON-GRANDFATHERED HEALTH BENEFIT PLAN

NOTICE

Healthcare services may be provided to You at a Network healthcare 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.

Important information regarding this Plan will be sent to the mailing address provided for a Plan Participant on their Employee Enrollment / Employee Change Form. Plan Participants are responsible for keeping the Claims Administrator and the Group informed of any changes in their address of record.

A handwritten signature in black ink, appearing to read "I. Steven Udvarhelyi".

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

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company

MAGNOLIA LOCAL PLUS
COMPREHENSIVE MEDICAL BENEFIT PLAN

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

As of the Original Effective Date of the Benefit Plan shown in the Schedule of Benefits, the Plan agrees to provide the Benefits specified herein for Plan Participants. A copy of this Benefit Plan provided to Plan Participants serves as the Plan Participant's certificate of coverage. This Benefit Plan replaces any others previously issued to the Plan Participant for this Plan.

Except for necessary technical terms, the Plan uses common words to describe the Benefits provided under this Plan. "We" "Us" and "Our" means Blue Cross and Blue Shield of Louisiana. 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. THE GROUP IS THE PLAN ADMINISTRATOR OF THIS PLAN. BLUE CROSS AND BLUE SHIELD OF LOUISIANA PROVIDES ADMINISTRATIVE CLAIMS SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS LIABILITY.

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.

FACTS ABOUT THIS PLAN

The OGB Magnolia Local Plus Benefit Plan for the State of Louisiana Plan Participants is a comprehensive straight HMO Group health plan. It has Copayment, Deductible and Coinsurance Benefits.

This Plan generally pays Benefits only when services are obtained from a Provider who is in the Preferred Care Network. Some services require Authorization before services are rendered. Services that require prior Authorization are listed on the Schedule of Benefits. **If an Authorization is required, but is not obtained before services are rendered, Benefits will be denied.**

Plan Participants have an extensive network of Providers (Network) available to them -- the PPO Network. Plan Participants usually pay a Copayment to a Network Provider at the time of service. Plan Participants choose which Providers will render their care. This choice could determine the amount We pay and the amount the Plan Participant pays for Covered Services.

This is a direct access plan. Plan Participants may see Specialists in the PPO Network without contacting a Primary Care Physician or obtaining a referral from a Primary Care Physician.

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

THE CLAIMS ADMINISTRATOR'S PROVIDER NETWORK

Plan Participants have the right to use Providers of their choice. The Plan Participant's choice of Provider will impact the amount the Plan Participant pays for Covered Services.

The Claims Administrator's Provider Network is called the PREFERRED CARE (OR PCARE) NETWORK. It consists of a select Group of Physicians, Hospitals and other Allied Providers that have contracted with the Claims Administrator to participate in the OGB HMO Preferred Care Provider Network and render services to the Plan Participants. These Providers are called "Network Providers." Plan Participants may access care at the Network level of Benefits when they see contracted PPO Providers in other states, through the BlueCard® Program. Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's dental network.

In an Emergency, Plan Participants should seek care from the nearest facility, even if that facility is not in the Claims Administrator's Network. For non-emergency care, the Plan Participant should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Network Provider before the service is rendered. Plan Participants may review a current paper Provider directory or search for a provider outside of the state of Louisiana under National Provider Directory in the Find Care section of www.bcbsla.com/ogb or on the free BCBSLA app for your iPhone or Android. Plan Participants may also contact the Claims Administrator's Customer Service Department at the number

on his ID card. A Provider's status may change. The Plan Participant 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.

Plan Participants do not have the option to choose care from Providers that are not in the PPO Provider Network. No Benefits will be paid for care from Providers outside the PPO Network unless: (1) The Claims Administrator determines that services are not available from a PPO Provider within a seventy-five (75) mile radius of the Plan Participant's home and We issue written approval to the Plan Participant to obtain the services outside the Network prior to the services being rendered; or (2) the Plan Participant has an Emergency Medical Service and is unable to obtain the care from a Network Provider.

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

AUTHORIZATIONS

CERTAIN SERVICES LISTED ON THE SCHEDULE OF BENEFITS REQUIRE AUTHORIZATION BY THE CLAIMS ADMINISTRATOR. IF AN AUTHORIZATION IS NOT OBTAINED PRIOR TO SERVICES BEING RENDERED, NO BENEFITS WILL BE PAID AND THE CLAIM WILL BE DENIED.

An Authorization is the Claims Administrator's determination that it is Medically Necessary for the Plan Participant to receive the requested medical services. When the Claims Administrator authorizes a service for Medical Necessity, the Claims Administrator is not making a determination about the Plan Participant's choice of Provider or the Benefits that will apply to a resulting Claim.

PRIOR AUTHORIZATION IS NOT REQUIRED FOR AN EMERGENCY MEDICAL SERVICE, AS DEFINED BY THIS BENEFIT PLAN.

Network Providers are required to obtain necessary Authorizations on behalf of the Plan Participant. When a Network Provider fails to obtain a required Authorization, the Plan penalizes the Network Provider, not the Plan Participant. The Plan Participant continues to be responsible only for the applicable Network Copayment, Deductible, and/or Coinsurance shown in the Schedule of Benefits. If a Plan Participant receives services outside of Louisiana, it is the Plan Participant's responsibility to obtain Prior Authorization from the Claims Administrator.

When the Claims Administrator issues an Authorization, but the Plan Participant receives the service from a Non-Network Provider, no Benefits are payable unless the Plan Participant obtained the Claims Administrator's written approval to obtain the services from the Non-Network Provider, **PRIOR TO THE SERVICES BEING RENDERED**. If the Plan Participant has received the Claims Administrator's written approval to use a Non-Network Provider, it is up to the Plan Participant to make sure that the approved Provider obtains any necessary Authorizations, or no Benefits will be paid.

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 or a transplant facility in a Blue Cross and Blue Shield of Louisiana PPO Provider Network, unless otherwise approved by the Claims Administrator and the Plan Administrator in writing. Evaluation for Tissue Transplant is not required. To locate an approved transplant facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their ID card.

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

HOW THE PLAN DETERMINES WHAT IS PAID FOR COVERED SERVICES

The Plan bases payments of Benefits for a Plan Participant's Covered Services on an amount known as the "Allowable Charge." The Allowable Charge depends on the Provider from whom the Plan Participant receives Covered Services as described below, and may be different for Network and Non-Network Providers.

If the amount that is billed for Covered Services by the Plan Participant's Provider is less than the amount that the Claims Administrator has negotiated for the Covered Service, the billed amount is the Allowable Charge and the Plan's payment will be based on the billed amount.

When a Plan Participant Uses Network Providers

Network Providers are Providers that have signed contracts with the Claims Administrator to participate in the PPO Network. These Providers have agreed to accept the lesser of billed charges or an amount the Claims Administrator 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 Covered Services and the amount that the Plan Participant must pay for his Covered Services.

EXCEPT AS DESCRIBED BELOW, IF A PLAN PARTICIPANT RECEIVES SERVICES OUTSIDE OF THE PPO PROVIDER NETWORK AND PRIOR WRITTEN APPROVAL AND/OR AUTHORIZATIONS ARE NOT OBTAINED (WHERE REQUIRED), THE SERVICES WILL NOT BE COVERED. IF WE HAVE ISSUED WRITTEN APPROVAL TO USE A NON-NETWORK PROVIDER, AND AUTHORIZATIONS ARE OBTAINED (WHERE REQUIRED), BENEFITS WILL BE PAID AS FOLLOWS:

The Claims Administrator will establish an Allowable Charge for Covered Services rendered by a Non-Network Provider. The Claims Administrator will use the lesser of the Provider's actual billed charge or the established Allowable Charge to determine what to pay for a Plan Participant's Covered Services when the Plan Participant receives care from a Non-Network Provider.

What the Claims Administrator pays when a Plan Participant receives Medically Necessary Emergency Medical Services from Non-Network Providers

When a Plan Participant receives Medically Necessary Emergency Medical Services from a Non-Network Provider, Benefits will be as follows: The Allowable Charge will be the lesser of the following:

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

This amount is the Non-Network Provider's Allowable Charge and it is used to determine the amount that We pay for the Plan Participant's Covered Services. If the Plan Participant received a Covered Emergency Medical Service from a Non-Network Provider and that Claim was denied, the Plan Participant may file an Appeal for consideration of Benefits. To file an Appeal, the Plan Participant must follow the Appeal procedures set forth in this Benefit Plan.

ASSIGNMENT OR ATTEMPTED ASSIGNMENT

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

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

HEALTH MANAGEMENT AND WELLNESS TOOLS AND RESOURCES

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

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 HEALTHCARE OUTSIDE OF LOUISIANA. IF THE PLAN PARTICIPANT IS TRAVELING OR RESIDING OUTSIDE OF LOUISIANA AND NEEDS MEDICAL ATTENTION, PLEASE FOLLOW THESE STEPS:

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

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands with a Blue Cross Blue Shield Global Core provider are covered at the Network Benefit level. NO benefits are payable for non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands from a non-Blue Cross Blue Shield Global Core Provider.

ARTICLE II.

DEFINITIONS

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

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

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

- A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or Investigational;
- B. the Plan Participant's eligibility to participate in the Benefit Plan;
- C. any prospective or retrospective review determination; or
- D. a Rescission of Coverage.

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

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

Allied Health Professional - A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, and/or approved by the Claims Administrator to render Covered Services. For coverage purposes under this Benefit Plan, Allied Health Professionals include, but are not limited to audiologists, dentists, psychologists, Retail Health Clinics, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, Physician assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, midwives, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by the Claims Administrator to render Covered Services.

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

Allowable Charge –

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

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 licensed, 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.

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 written request from a Plan Participant or Authorized Representative to change an Adverse Benefit Determination made by the Claims Administrator.

Applied Behavioral 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 as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state.

Authorization (Authorized) – A determination by Claims Administrator regarding an Admission, continued Hospital stay, or other healthcare service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the healthcare setting, or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Plan Participant's choice of Provider. Services requiring an Authorization are listed on the Schedule of Benefits. Failure to obtain an Authorization will result in no Benefits paid and the Claim will be denied.

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

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

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

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

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

Brand-Name Drug – A Prescription Drug that is a patented drug marketed by the original drug manufacturer following its Food and Drug Administration ("FDA") approval, or that the Pharmacy Benefits Administrator identifies as a Brand-

Name product. All products identified as a “Brand Name” by the manufacturer or pharmacy may not be classified as a Brand-Name Drug by the Pharmacy Benefits Manager.

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

Child or Children includes:

1. A Child of the Employee/Retiree;
2. A Child of the Employee's/Retiree's Spouse (a “stepchild”);
3. A Child placed for adoption with the Employee/Retiree;
4. A Child under the court-ordered legal guardianship or in the court-ordered custody of the Employee/Retiree;
5. A grandchild or dependent of a dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent, or a child for whom the Employee/Retiree has current provisional custody, which grandchild/child has not been adopted by the Employee/Retiree and for whom the Employee/Retiree has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a “Child” as of December 31, 2015.

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

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

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

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

COBRA - 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.

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

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

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

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.

Copayment - The specific dollar amount a Plan Participant must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment will be collected directly from a Plan Participant by a Network Provider. All Copayments apply toward the Plan Participant's Out-of-Pocket Maximum.

Cosmetic Surgery - Any operative procedure, treatment or service, or any portion of an operative procedure, treatment or service performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form. An operative procedure, treatment or service 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 or Retiree, his eligible Dependent(s), or any other individual eligible for coverage under the Schedule of Eligibility or state or federal law for whom the necessary application forms have been completed, for whom the required contribution has been made, and for whom the Plan Administrator has accepted Eligibility and enrolled into the Plan. The term 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.

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, 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. 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:

- A. Spouse – the date of marriage
- B. Child or Children
 - 1. Natural Children – the date of birth

2. Children placed for adoption with the Employee/Retiree

Agency adoption – the date the adoption contract was executed between the Employee/Retiree and the adoption agency.

Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee/Retiree. The Plan Administrator must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first.

3. Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship – the date of the court order granting legal custody or guardianship.

4. Stepchild – the date of the marriage of the Employee/Retiree to his/her Spouse.

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

Deductible Amount – The dollar amount that a Plan Participant must pay within a Benefit Period before Benefit Payments are made by the Plan.

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.

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.

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

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

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

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

Dependent – 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/Retiree, and (b) whose relationship to the Employee/Retiree has been documented, as defined herein:

A. the covered Employee's/Retiree's Spouse;

B. a Child from Date Acquired until end of month of attainment of age twenty-six (26), except for the following:

1. A grandchild or dependent of a dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which grandchild or dependent of a dependent was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until end of month the parent Dependent Child is no longer enrolled on or eligible to participate in the Plan, the end of the month the grandchild or dependent of a dependent turns twenty-six (26), or the grandchild or dependent of a dependent no longer meets the eligibility requirements under this Plan, whichever is earlier;

2. A child for whom the Employee/Retiree has current provisional custody and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which child was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until the end of the month of the 2016 anniversary date of the existing provisional custody document, the end of the month the child reaches the age of eighteen (18), or December 31, 2016, whichever is earlier;
3. A Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship/tutorship but who has not been adopted by the Employee/Retiree, from Date Acquired until the end of the month the custody/guardianship/tutorship order expires or the end of the month the Child reaches the age of eighteen (18), whichever is earlier;
4. A stepchild of the Employee/Retiree, which stepchild has not been adopted by the Employee/Retiree and for whom the Employee/Retiree does not have court-ordered custody or court-ordered legal guardianship/tutorship, from Date Acquired until the end of the month that the Employee/Retiree is no longer married to the stepchild's parent, the end of the month of the death of the parent of the stepchild, or the end of the month the stepchild reaches the age of twenty six (26), whichever is earlier.

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 the Plan recognizes 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/Retiree) – the following written proof of relationship to the Employee/Retiree has been presented for inspection and copying to OGB, or to a representative of the Employee's/Retiree's Participant Employer designated by OGB:

- A. The covered Employee's/Retiree's Spouse - Certified copy of certificate of marriage indicating date and place of marriage.
- B. Child
 1. Natural or legally adopted Child of Employee/Retiree - Certified copy of birth certificate listing Employee/Retiree as parent, or certified copy of legal acknowledgment of paternity signed by the Employee/Retiree, or certified copy of adoption decree naming Employee/Retiree as adoptive parent.
 2. Stepchild - Certified copy of certificate of marriage to Spouse and birth certificate or adoption decree listing Spouse as natural or adoptive parent.
 3. Child placed with Your family for adoption by agency adoption or irrevocable Act of Voluntary Surrender for private adoption - Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable Act of Voluntary Surrender.
 4. Child for whom You have been granted court-ordered legal guardianship or court-ordered custody - Certified copy of the signed court order granting legal guardianship or custody.
- C. Child age twenty-six (26) or older who is incapable of self-sustaining employment and who was covered prior to and upon attainment of age twenty-six (26) - Documentation as described in B1. through B. 4. 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/Retiree deemed sufficient by OGB.

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

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

Elective Admission - Any Inpatient Hospital Admission, whether it is 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 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 the respective Participant Employer in accordance with state law, and any Full-Time Equivalent.

Enrollment Date - The first day of coverage under this Benefit Plan.

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

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

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

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

External Appeal – A request for review by an Independent Review Organization (IRO), to change an initial Adverse Benefit Determination made by the Company or to change a final Adverse Benefit Determination rendered on Appeal. External Appeal is available upon request by the Plan Participant or authorized representative for Adverse Benefit

Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission of Coverage.

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

Full Time Equivalent(FTE) – A full-time equivalent Employee who is employed on average 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 Pharmacy Benefits Manager identifies as a Generic Drug. Classification of a Prescription Drug as a Generic Drug is determined by the Pharmacy Benefits Manager and not by the manufacturer or pharmacy. All products identified as a “Generic” by the manufacturer or a pharmacy may not be classified as a Generic by the Pharmacy Benefits Manager.

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

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

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

High-Tech Imaging – Imaging services, including, but not limited to MRIs, MRAs, CT scans, PET scans and nuclear cardiology.

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

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

Home Health Care - Health services rendered in the individual’s place of residence by an organization licensed as a Home Health Care agency by the appropriate state agency and that the Claims Administrator approves. 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 that the Claims Administrator approves.

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 rehabilitation, skilled nursing, long term, intermediate care, or other specialty care.

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 Us, which conducts external reviews of final Adverse Benefit Determinations. The decision of the IRO is binding on both the insured and the Company.

Infertility – The inability of a couple to conceive after one 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.

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.

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

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

- A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the 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.

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

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

- 1. Is appropriate and consistent with a Covered Person's diagnosis and treatment as well as with nationally accepted medical standards; and

2. Is not primarily for personal comfort or convenience, Custodial Care, or Convalescent/Maintenance Care or Rest Cure.

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 shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Network Benefits - Benefits for care received from a Network Provider.

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

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

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

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.

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.

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, of unreimbursable expenses which must be paid by a Plan Participant or family unit for Covered Services in one (1) Benefit Period.

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

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

Pain Rehabilitation Control and/or Therapy - A program designed to develop an individual's ability to control or tolerate chronic pain.

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

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

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

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

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

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

Prescription Drug Copayment – The amount a Plan Participant must pay for each Formulary 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 or Wellness Care (Routine Care)–Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage.

Primary Care Physician (PCP) – A Physician who is a Family Practitioner, General Practitioner, Internist, Geriatrician or Pediatrician and who has signed an agreement to participate in the Preferred Care PPO Network.

Private Duty Nursing Services - Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN), to provide continuous skilled nursing care, on-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 the Plan Participants in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

- A. Preferred Provider (Preferred Care Provider) – A Provider who has entered into a contract with the Claims Administrator to participate in its Preferred Care PPO Network, as shown in the Schedule of Benefits. This Provider is also referred to as a Network Provider.
- B. Participating Provider – A Provider that does not have a signed contract with the Claims Administrator, but has a signed contract with Our parent company, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan to participate in its Provider networks.
- C. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.
- D. Quality Blue Primary Care Provider – A Provider who is a family practitioner, general practitioner, internist, geriatrician or nurse practitioner and who has signed an agreement to participate in the Quality Blue Primary Care program.

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 - Healthcare services and devices that help a person keep, resume or improve skills and functioning for daily living that have been lost or impaired because a patient was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

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

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

Retiree - An individual, who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

- A. Immediately received a retirement plan distribution from an approved state or governmental agency defined benefit plan;
- B. Was not eligible for participation in such plan or legally opted not to participate in such plan; and either:
 - 1. Began employment prior to September 15, 1979, has ten (10) years of continuous state service, and has reached the age of sixty-five (65); or
 - 2. Began employment after September 16, 1979, has ten (10) years of continuous state service, and has reached the age of seventy (70); or
 - 3. Began employment after July 8, 1992, has ten (10) years of continuous state service, has a credit for a minimum of forty (40) quarters in the Social Security system at the time of employment, and has reached the age of sixty-five (65); or
 - 4. Maintained continuous coverage with the Plan as an eligible Dependent until he became eligible to receive a retirement benefit from an approved state governmental agency defined Benefit Plan as a former State Employee.
- C. Immediately received a retirement plan distribution from a state-approved or state governmental agency approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system

responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.

- D. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items A, B or C above.

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

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

Special Care Unit - A designated Hospital unit that is approved by the Claims Administrator and 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 Benefit Plan) within thirty (30) days of experiencing a HIPAA Special Enrollment Event, including but not limited to, losing other comparable health coverage under certain circumstances enumerated by Law (unless a longer period is required by applicable Law) or acquiring a new Dependent as a result of marriage, birth, adoption, or placement for adoption.

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

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

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

Speech/Language Pathology Therapy - The treatment used to manage speech/language, cognitive-communication and swallowing disorders, with the goals directed towards improving or restoring function.

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

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

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

Surgery

- A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, 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.
- E. Other procedures that the Claims Administrator defines and approves.

Telehealth Services – A mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, self-management of patients, and caregiver support at a distance from healthcare Providers. Telehealth allows services to be accessed when Providers are in a distant site and patients are in the originating site. Interaction between Provider and patient must be held by two-way video and audio transmissions simultaneously. Telehealth does not cover telephone conversations or electronic mail messages between Provider and patient, and must be medically appropriate for the setting in which the services are provided.

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

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

Temporomandibular/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 a Plan Participant's Physician's normal business hours.

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

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

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

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

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

ARTICLE III.

SCHEDULE OF ELIGIBILITY

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

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

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

- (1) For new full-time Employees, if employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if hired on July 1st, coverage will begin on August 1st).
 - (2) For new full-time Employees, if employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15th, coverage will begin on September 1st).
 - (3) Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.
 - (4) An Employee who transfers employment to another Participant Employer must complete a transfer form within thirty (30) days following the date of transfer to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.
 - (5) An Employee who is determined to be a FTE will be allowed to enroll in the Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth month of employment for those Employees determined to be FTEs during their initial measurement period.
- d. Re-Enrollment for Health and/or Life Benefits
 - (1) Full-time Employees returning to full time or part-time status with less than thirteen (13) weeks (less than 26 weeks for educational institutions) since separation or termination may resume coverage if application is made within thirty (30) days following return to work. Coverage will resume on the first of the month following return to work.

- (2) If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within thirty (30) days of re-employment.

e. Board and Commission Members

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

f. Legislative Assistants

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

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

2. Retiree Coverage - Eligibility

- a. Retirees of Participant Employers are eligible for Retiree coverage under this Plan.
- b. Retirees of Participant Employers may not be covered as an Employee.
- c. Effective Date of Coverage - Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions. For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. For example, if date of retirement is July 15, retiree coverage will begin August 1; if date of retirement is August 1, retiree coverage will begin September 1.

3. Documented Dependent Coverage - Eligibility

- a. Documented Dependent of an eligible Employee or Retiree will be eligible for Dependent coverage on the latest of the following dates:
 - (1) The date the Employee becomes eligible;
 - (2) The date the Retiree becomes eligible; or
 - (3) The Date Acquired for Employee's/Retiree's Dependents.
- 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 Acquired.
 - (2) Documented Dependents of Retirees -Coverage will be effective on the first day of the month following the date of retirement if the Retiree and his Dependents were covered immediately prior to retirement. Coverage for Dependents of Retirees first becoming eligible for Dependent coverage following the date of retirement will be effective on the Date Acquired.
- c. NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE.

4. HIPAA Special Enrollment Events

Certain eligible persons may enroll in the Plan if they experience a HIPAA Special Enrollment Event as provided by federal law. HIPAA Special Enrollment Events include but are not limited to birth, adoption, placement for adoption, marriage, eligibility for premium assistance subsidy under Medicaid or State Children's Health Insurance Program (SCHIP) coverage, loss of other health coverage through divorce, legal separation, or annulment, and loss of eligibility based on termination of Medicaid or SCHIP coverage. Application to the Plan Administrator must be made within thirty (30) days of the HIPAA special enrollment event unless a longer period is provided by federal law or by OGB.

5. Other Special Enrollment or Disenrollment Events

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

6. Medicare Advantage Option for Retirees other than OGB sponsored plans

Retirees who are eligible to participate in a Medicare Advantage plan sponsored by OGB who cancel coverage with the Plan upon enrollment in such Medicare Advantage plan may re-enroll in the Plan upon withdrawal from or termination of coverage in the Medicare Advantage plan, during the next Annual Enrollment, for coverage effective at the beginning of the next Plan Year.

Retirees who elect to participate in a Medicare Advantage plan not sponsored by OGB will not be allowed to reenroll in a plan offered by OGB upon withdrawal from or termination of coverage in the Medicare Advantage plan.

7. TRICARE for Life Option for Military Retirees

Retirees eligible to participate in the TRICARE for Life (TFL) option on and after October 1, 2001, who cancel coverage with the Plan upon enrollment in TFL may re-enroll in the Plan in the event that the TFL option is discontinued or its Benefits significantly reduced.

B. Continued Coverage

1. Leave of Absence

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

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

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

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

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

2. Disability

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

3. Surviving Dependents/Spouse

- a. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.
 - (1) The surviving Spouse of an Employee or Retiree 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 or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a group health plan other than Medicare or until end of the month of the attainment of the termination age for that specific Dependent Child, whichever occurs first.
 - (3) Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees and Retirees, 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 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) The Participant Employer and/or surviving covered Dependent shall notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree.
 - (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:
 - (a) Failure to pay the applicable premium timely.
 - (b) 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:
- (a) Failure to pay the applicable premium timely.
 - (b) Eligibility of the surviving Dependent child for coverage under any group health plan other than Medicare; or
 - (c) The end of the month of attainment of the termination age for that specific Dependent Child.
- d. The provisions of 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 or Retiree.

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

4. Over-Age Dependents

If a Dependent Child is incapable (and became incapable prior to attainment of age twenty-six (26)) of self-sustaining employment, 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, along with the Child's attending Physician's attestation of the Child's incapacity to perform self-sustaining employment, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.
- b. Upon receipt of the application for continued coverage and Physician's attestation, the Plan Administrator may require additional medical documentation regarding the Dependent Child's incapacity as often as it may deem necessary as a precondition to continue coverage.

5. Military Leave

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

- a. Health Plan Participation- When an Employee is called to active military duty, the Employee and his/her covered eligible Dependents may:
 - (1) continue participation in the health plan during the period of active military service, in which case the Participant Employer may continue to pay its portion of premiums; or
 - (2) cancel participation in the health plan during the period of active military service, in which case the Employee may apply for reinstatement of OGB coverage within thirty (30) days of:
 - (i) the date of the Employee's re-employment with a Participant Employer; or
 - (ii) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Employees who elect this option and timely apply for reinstatement of OGB coverage, the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E 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. The Participant Employer shall notify the Plan Administrator within thirty (30) days of the date coverage would have terminated because of any of the foregoing events. OGB's third-party COBRA vendor ("COBRA Administrator") will notify the Employee within fourteen (14) days of his right to continue coverage.
- c. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification, and premium payment must be made to the COBRA Administrator within forty-five (45) days of the date the Employee elects continued coverage. 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/Retirees.
- 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/Retiree will terminate on the last day of the month in which the Employee's/Retirees death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.
- b. The Participant Employer and/or surviving covered Dependents shall notify the Plan Administrator within thirty (30) days of the death of the Employee/Retiree. The COBRA Administrator will notify the surviving Dependents of their right to continue coverage within fourteen (14) days of his right to continue coverage.. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification.
- c. Premium payment must be made to the COBRA Administrator within forty-five (45) days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for the surviving Dependents under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable 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/Retirees.

3. Ex-Spouse/Ex-Stepchildren – Divorce, Annulment or Legal Separation

- a. Coverage under this Plan for an Employee's/Retiree's Spouse (and any stepchildren enrolled on the Plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment, or legal separation from the Employee/Retiree, unless the covered ex-Spouse elects to continue coverage at his/her own expense.
- b. The Employee/Retiree or the ex-spouse/ex-stepchild shall notify the Plan Administrator of the divorce, annulment, or legal separation within sixty (60) days from the date of the divorce, annulment, or legal separation. The COBRA Administrator will notify the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) within fourteen (14) days of his/her/their right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the election notification.
- c. Premium payment must be made to the COBRA Administrator within forty-five (45) days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) 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/Retirees.

4. Dependent Children

- a. Coverage under this Plan for a covered Dependent Child will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent Child elects to continue coverage at his own expense.
- b. The Dependent Child shall notify the Plan Administrator of his loss of eligibility within sixty (60) days of the date coverage would have terminated. The COBRA Administrator will notify the Dependent Child within fourteen (14) days of his/her right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of receipt of the election notification.
- c. Premium payment must be made to the COBRA Administrator within forty-five (45) days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for a Dependent Child under this section will continue until the earliest of the following:

- (1) Failure to pay the applicable 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/Retirees.

5. Dependents of COBRA Participants

- a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered Spouse or a covered Dependent Child becomes ineligible for coverage due to:
 - (1) Death of the Employee,
 - (2) Divorce, Annulment, or Legal Separation from the Employee, or
 - (3) A Dependent Child no longer meets the definition of an eligible covered Dependent, then, the Spouse and/or Dependent Child may elect to continue COBRA coverage at his/her own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.
- b. The Spouse and/or the Dependent Child shall notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.
- c. Monthly payments for each month of COBRA coverage are due to the COBRA Administrator 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/Retirees.

6. Disability COBRA

- a. If a Plan Participant is determined by the Social Security Administration or by the COBRA Administrator staff (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient quarters of employment) to have been totally disabled on the date the Plan Participant became eligible for continued coverage or within the initial eighteen (18) months of continued coverage, coverage under this Plan may be extended at his own expense up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated.
- b. To qualify for disability COBRA, the Plan Participant must:
 - (1) Submit a copy of his/her Social Security Administration's disability determination to the COBRA Administrator before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:
 - (a) The date of issuance of the Social Security Administration's disability determination; and

- (b) 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 COBRA Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the COBRA Administrator will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.
- c. For purposes of eligibility for extended continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of twelve (12) months.

To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

- d. Monthly payments for each month of extended disability COBRA coverage are due to the COBRA Administrator 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/Retirees; or
 - (6) Thirty (30) days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Plan Administrator and the COBRA Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the COBRA Administrator determines that the Covered Person is no longer disabled.

7. Medicare COBRA

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

- b. Monthly payments for each month of COBRA coverage are due to the COBRA Administrator on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

8. Miscellaneous Provisions

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

D. Change of Classification

1. Adding or Deleting Dependents

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

2. Change in Coverage

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

3. Notification of Change

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

E. Contributions

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

F. Medical Child Support Orders

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

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

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

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

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

G. Termination of Coverage

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

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

ARTICLE IV.

BENEFITS

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

NO BENEFITS ARE AVAILABLE FOR ANY SERVICE THAT REQUIRES AN AUTHORIZATION OR FOR ORGAN, AND BONE MARROW TRANSPLANTS OR EVALUATIONS, IF AUTHORIZATION IS NOT RECEIVED PRIOR TO SERVICES BEING RENDERED.

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

A. Benefit Categories

1. Network Benefits (In-Network): Benefits for Covered Services from a Network Provider (Providers contracted with the Claims Administrator in the PPO Network). When a Plan Participant receives care from a Network Provider, he will receive the highest level of Benefits on this Plan.
2. Non-Network Benefits (Out-of-Network): Benefits for Covered Services received from a Provider who is not contracted with the Claims Administrator in the PPO Network. When a Plan Participant receives care from a Non-Network Provider, the services are not covered on this Plan unless specified in the Schedule of Benefits.

B. Deductible Amount

1. Subject to the Deductible Amount 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 an individual Plan Participant must pay within a Benefit Period before the Plan starts paying benefits.
 - 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 Benefit Plan starts paying Benefits.
2. We 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 to whom the overpayment was made.

3. Under certain circumstances, if the Claims Administrator pays the Provider amounts that are the Plan Participant's responsibility, such as Deductibles, Copayments 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 from You.

C. Copayment Services

If a Copayment is shown for a Covered Service, the Plan Participant must pay the applicable Copayment each time the Covered Service is rendered, until the Plan Participant meets his Out-of-Pocket Maximum. The amount of the Copayment depends on the type of Network Provider rendering the service. Office visit Copayments, if applicable, will be at the Primary Care Physician or Specialist amount shown on the Schedule of Benefits.

D. Coinsurance Amount

If a Coinsurance is shown on the Schedule of Benefits for a Covered Service, the Plan Participant must first pay any applicable Benefit Period Deductible Amount before the Coinsurance. After any Deductible Amounts shown in the Schedule of Benefits have been met, the Claims Administrator will provide payment based on the Coinsurance shown in the Schedule of Benefit toward the Allowable Charges for Covered Services. The Claims Administrator's actual payment to a Provider or payment to the Plan Participant satisfies the Plan Administrator's obligation to provide Benefits under this Plan. The Plan Participant may be balance billed by the Provider when services outside the Network are obtained.

E. Out-of-Pocket Maximum

1. After the Plan Participant has met the applicable Out-of-Pocket Maximum shown in the Schedule of Benefits, the Claims Administrator will pay one hundred percent (100%) of the Allowable Charge for Covered Services for the remainder of the Benefit Period.
2. The following apply toward the Out-of-Pocket Maximum of this Benefit Plan:
 - a. Deductibles;
 - b. Coinsurances;
 - c. Copayments.
3. The following do not apply toward the Out-of-Pocket Maximum of this Benefit Plan:
 - a. any charges in excess of the Allowable Charge;
 - b. any penalties the Plan Participant or Provider must pay;
 - c. charges for non-covered services;
 - d. any amounts paid by the Plan Participant other than Deductibles, Coinsurance and Copayments.

F. Accumulator Transfers

If necessitated as a direct result of a HIPAA Special Enrollment Event or COBRA Qualifying Life Event, Plan Participants may transfer from one of the Group's self-insured plans to another Group self-insured Plan with the same Claims Administrator. 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 and Benefit Period Maximums.

ARTICLE V. HOSPITAL BENEFITS

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

If a Plan Participant receives services from a Physician in a hospital-based clinic, the Plan Participant may be subject to charges from the Physician and/or clinic as well as the facility. The following services furnished to a Plan Participant by a Hospital are covered:

A. Inpatient Bed, Board and General Nursing Service

1. 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 Use Disorder condition.

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. Covered Services of a Physician;
5. Routine Nursing Services, i.e., "floor nursing" services provided by nurses employed by the hospital are considered as part of the room and board;
6. Diagnostic testing, including, but not limited to, laboratory examinations and x-rays;
7. Nuclear medicine and electroshock therapy;
8. Blood, blood derivatives, and blood processing, when not replaced;
9. Surgical and medical supplies billed for treatment received in a Hospital or Ambulatory Surgical Center.
10. Intravenous injections, solutions, and related intravenous supplies;
11. Physical Therapy provided by a Hospital employee;
12. Psychological testing ordered by the attending Physician and performed by a Hospital employee.

D. Emergency Room

The Plan Participant may have to pay applicable Copayment, Deductible and/or Coinsurance Amounts as shown in the Schedule of Benefits, for each visit to an Emergency room for treatment. The Emergency room Facility Charge Copayment is waived if an Emergency visit results in an Inpatient Admission to the same Facility as where the Emergency room is located. 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 Copayments, Deductible Amounts and Coinsurance percentages 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 Claims Administrator 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 the Claims Administrator.
- (2) The Allowable Charge includes the rebundled procedure. The Claims Administrator 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 and approved by the Claims Administrator. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.
- b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless the Claims Administrator determines otherwise.
- c. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

5. Second Surgical Opinion

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

B. Inpatient Medical Services

Subject to provisions in the sections pertaining to Surgery and Pregnancy Care in this Benefit Plan, Inpatient Medical Services include:

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

C. Outpatient Medical and Surgical Services

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

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. Each Plan Participant acknowledges and accepts the Pharmacy Benefit Manager designated by OGB from time to time and agrees to receive communications from the Pharmacy Benefit Manager for purpose of administering any OGB pharmacy benefits or prescription drug program. See the Schedule of Benefits for more information.

ARTICLE VIII. PREVENTIVE OR WELLNESS (ROUTINE) 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 services are not covered on this Plan. Preventive or Wellness Care services may be subject to other limitations and Exceptions 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 Preventive or Wellness Care may be subject to the Copayments, Deductible Amount and/or Coinsurance as shown in the Schedule of Benefits.
2. One (1) routine Pap smear per Benefit Period.
3. One (1) mammography examination per Benefit Period. Additional mammography examinations recommended by the Plan Participant's Physician may be subject to Copayments, Deductible Amount and/or Coinsurance as 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 include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels.

High-Tech Imaging services such as an MRI, MRA, CT scan, PET scan, and nuclear cardiology are not covered under this Preventive or Wellness Care Benefit. These High-Tech Imaging services are covered as described in this Benefit Plan, including as described in Article IV Benefits so that such services may be subject to copayments, deductibles and coinsurance.

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

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 FIT (Fecal Immunochemical Test) for blood, flexible sigmoidoscopy, or colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

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

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

One (1) osteoporosis screening, per Benefit Period, is available at no cost to the Plan Participant, for women age 65 and older, when care is received from a Network Provider.

C. Immunizations (Benefit Period Deductible does not apply)

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

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

In addition to the Preventive or Wellness (Routine) Care, the Plan will cover 100% of the Allowable Charges from Network providers, for 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: <https://www.healthcare.gov/preventive-care-benefits> 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 AND SUBSTANCE USE DISORDER

- 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 treatment for Mental Disorders must be Authorized as provided in the Care Management Article of this Benefit Plan.
- C.** Plan Participants who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis when the Claims Administrator Authorizes it for treatment of Autism Spectrum Disorders. Applied Behavior Analysis must be rendered by an appropriately licensed behavior analyst or certified assistant behavior analyst.
- D.** Benefits for treatment of substance use disorder are available. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.
- E.** Inpatient treatment for substance use disorder must be Authorized as provided in the Care Management Article of this Benefit Plan, when coverage for substance use disorder is provided.

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

ARTICLE X. ORAL SURGERY AND DENTAL SERVICES

A. Surgical Services

Benefits are available for the following oral and maxillofacial surgeries:

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

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

B. Dental Services

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

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

C. Anesthesia Services

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

ARTICLE XI. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS *(Benefits available from Network Providers only)*

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 a Plan Participant obtains written Authorization from the Claims Administrator prior to services being rendered. The Plan Participant or his Provider must advise the Claims Administrator of the proposed transplant procedure prior to Admission and a written request for Authorization must be filed with the Claims Administrator. The Claims Administrator must receive adequate information to verify coverage, determine that the procedure is Medical Necessary, and approve the site at which the transplant procedure will occur. The Claims Administrator will forward written Authorization to the Plan Participant and to the Provider(s).

A. Acquisition Expenses

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 Plan Participant, 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 Transplants

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) **for the specific organ or transplant** or a Blue Cross and Blue

Shield of Louisiana (BCBSLA) Network facility, unless otherwise approved by the Claims Administrator and the Plan Administrator in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities.

To locate an approved Network transplant 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 under the Non-Network Benefit category.
3. Benefits for organ, tissue and bone marrow transplants include coverage for immunosuppressive drugs administered for transplant procedure(s). No Benefits are available under this Benefit Plan for immunosuppressive drugs received after an Inpatient Admission ends.

Benefits as specified in this section will be provided for treatment and care because of or directly related to the following transplant procedures:

C. Solid Human Organ Transplants of the:

1. liver;
2. heart;
3. lung;
4. kidney;
5. pancreas;
4. small bowel; and
7. other solid organ transplant procedures, which the Claims Administrator determines has 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)

The following tissue transplants (other than bone marrow) are covered under the Medical and Surgical Benefits Article, and do not require prior Authorization. Evaluation for Tissue Transplant is not required. If an Inpatient Admission is required, it is subject to the Care Management Article.

These following tissue transplants are covered:

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

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. The storage of autologous bone marrow is covered for a period not to exceed thirty (30) days.
3. Other bone marrow transplant procedures, which the Claims Administrator determines, have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These bone marrow transplant procedures will be considered on a case-by-case basis.

ARTICLE XII. PREGNANCY AND NEWBORN CARE BENEFITS

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

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

Benefits for treatment of ectopic pregnancies and spontaneous abortions (miscarriages) are available for all Plan Participants under Articles V and 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 cesarean section. Authorization must be requested within twenty-four (24) hours of the initial exceedance of the forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a newborn's stay exceeds that of the mother. An Authorization is also required for a newborn that is admitted separately because of neonatal complications.

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

A. Pregnancy Care

1. Medical and Surgical Services
 - a. Initial office visit and visits during the term of the pregnancy.
 - b. Diagnostic Services.
 - c. Delivery, including necessary prenatal and postnatal care.
 - d. Medically Necessary abortions required to save the life of the mother.
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 Benefits 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. Pregnancy Care Copayment, Deductible, Coinsurance

A Pregnancy Care Copayment, as shown in the Schedule of Benefits, applies to Covered Services rendered by Network Providers, for each covered pregnancy. The Plan Participant must pay all applicable Hospital Copayments, Deductibles and/or Coinsurance for any hospitalization related to the pregnancy, as shown in the Schedule of Benefits, in addition to any applicable Pregnancy Care Copayments.

B. Care for Newborn when Covered at birth as a Dependent

The Plan Participant must pay all applicable Copayments, Deductible and Coinsurance as shown in the Schedule of Benefits for Covered Services.

1. Medical and surgical services rendered by a Physician, for treatment of illness, pre-maturity, 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 under the Network Benefit category only. Hospital nursery charges;
2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, pre-maturity, 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 a well newborn is included in the mother's Hospital bill for the covered portion of her Admission for Pregnancy Care.

An Inpatient Hospital Admission Copayment applies to the Admission of an ill/sick newborn for treatment in a Network Hospital. The Plan will provide Benefits of one hundred percent (100%) of the Allowable Charges for such treatment, less the Plan Participant's Copayment.

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, certified nurse midwife, or physician assistant), after Consultation with the mother, discharges the mother or Newborn earlier.

Also, under federal law, the Plan 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 healthcare 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 Prior Authorization. For information on Prior Authorization, contact Your Claims Administrator.

ARTICLE XIII. REHABILITATIVE CARE BENEFITS

Rehabilitative Care Benefits will be available for services and devices provided on an Inpatient or Outpatient basis, including services for Hearing Therapy, Cognitive Therapy, Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, and/or Chiropractic Services. Visit limits may apply as provided in the Schedule of Benefits.

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

An Inpatient rehabilitation Admission must be Authorized prior to the Admission and must begin within seventy-two (72) hours following the discharge from an Inpatient Hospital Admission for the same or similar condition.

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 and if Benefits are provided for the following:
 - a. to children with a diagnosed developmental disability pursuant to the patient's plan of care;
 - b. as part of a Home Health Care agency pursuant to the patient's plan of care;
 - c. to a patient in a nursing home pursuant to the patient's plan of care;
 - d. related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness;
 - e. to an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered, as 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 by 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 the receipt of services.

D. Hearing Therapy

Benefits are available under this Plan for hearing therapy, as shown in the Schedule of Benefits.

E. Cognitive Therapy

Benefits are available under this Plan for cognitive therapy, as shown in the Schedule of Benefits.

F. Pulmonary Therapy

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

G. Chiropractic Services

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

Maintenance therapy is not covered except for periodic visits to reinforce any need for therapy or current therapeutic objectives.

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

ARTICLE XIV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

The following services are available to a Plan Participant. The Plan Participant must pay all Copayments, applicable Deductible Amounts and Coinsurance. These services, supplies or equipment may also be subject to other limitations, as shown in the Schedule of Benefits.

A. Acute Detoxification

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

B. 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 Participants, 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.

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

3. Ambulance Service Benefits will be provided as follows:

- a. If a Plan Participant pays a periodic fee to an ambulance membership organization with which 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.

C. Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder when rendered or prescribed by a Non-Psychiatric Provider is covered the same as any other illness.

D. Bone Mass Measurement

Benefits are available for scientifically proven non-routine 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, Coinsurance and/or Copayment amounts may be applicable.

E. Breast Reconstructive Surgery Services

Breast Reconstructive Surgery Services shall be delivered in a manner determined in Consultation with the Plan Participant and the Plan Participant's attending Physician, if applicable, and will be subject to any Deductible Amounts, Copayments and Coinsurance.

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

F. Cleft Lip and Cleft Palate Services

Covered Services include the following:

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

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

G. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other Life-Threatening Illness or condition. Coverage will be subject to any applicable terms, conditions and limitations that apply under this Benefit Plan, including Copayment, Deductible, or Coinsurance amounts, as 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 Illness or condition;
 - b. And either,
 - (1) The referring healthcare professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the requirements in paragraph a, above; or
 - (2) The Plan Participant provides medical and scientific information establishing that the Plan Participant's participation in such trial would be appropriate based upon the Plan Participant meeting the conditions described in paragraph a, above.
3. An "Approved Clinical Trial" for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Illness or condition that:
 - a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - (1) The National Institutes of Health.

- (2) The Centers for Disease Control and Prevention.
 - (3) The Agency for Health Care Research and Quality.
 - (4) The Centers for Medicare & Medicaid Services.
 - (5) Cooperative group or center of any of the entities described in paragraphs (1) through (4) or the Department of Defense or the Department of Veterans Affairs.
 - (6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- b. The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.
 - c. The study or investigation is a drug trial that is exempt from having an Investigational new drug application.
 - d. The study or investigation is conducted by any of the below Departments, which study or investigation has been reviewed and approved through a system of peer review that the 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:
 - (1) The Department of Veterans Affairs.
 - (2) The Department of Defense.
 - (3) The Department of Energy.
4. The following services are not covered:
- a. Non-healthcare services provided as part of the clinical trial;
 - b. Costs for managing research data associated with the clinical trial;
 - c. The Investigational drugs or devices, items or services themselves; and/or
 - d. Services, treatment or supplies not otherwise covered under this Plan.
5. Treatments and associated protocol-related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:
- a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other Life-Threatening Illness or for the prevention or early detection of such diseases.
 - b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial.
 - c. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.
 - d. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
 - e. There must be no clearly superior, non-Investigational approach.

- f. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-Investigational alternative.
- g. The patient has signed an institutional review board approved consent form.

H. Diabetic 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 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 healthcare professional that certifies that a 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. Diabetic supplies are only covered when billed by a medical Provider.
- 4. Plan-eligible and approved diabetic supplies including Insulin Reservoir and Insulin pump supplies, as prescribed by a Physician, will be covered at no cost when received from an In-Network PPO Provider; the cost will not go toward Your deductible.

I. Disposable Medical Equipment or Supplies

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

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

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

- 1. Durable Medical Equipment
 - a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be provided mainly for the comfort or convenience of the Plan Participant or others. In addition, the equipment must meet all of the following criteria:
 - (1) it must withstand repeated use;
 - (2) it is primarily and customarily used to serve a medical purpose;
 - (3) it is generally not useful to a person in the absence of illness or injury; and
 - (4) it is appropriate for use in the patient's home.
 - b. Benefits for rental or purchase of Durable Medical Equipment.
 - (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge);
 - (2) At the Claims Administrator's option, on behalf of the Plan Administrator, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, oxygen and oxygen equipment

required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge;

- (3) 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 except as specified in 1.4 above;
- (6) repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. 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.

c. Limitations in connection with Durable Medical Equipment.

- (1) there is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier;
- (2) there is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose;
- (3) there is no coverage for 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 Authorized by the Claims Administrator. These Benefits will be subject to the following:

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.
- b. Repair or replacement of the Orthotic Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. The Claims Administrator 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 or hammertoe.

3. Prosthetic Appliances, Devices and Prosthetic Services of the Limbs (Non-Limb and Limb)

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

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.
- b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Claims Administrator will determine this time period.
- c. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.
- d. Mastectomy bras, limited to 3 (three) per Plan Year.
- e. 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 Benefit 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.
- f. 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. Emergency Medical Services

A Plan Participant must pay an Emergency room Copayment, as shown in the Schedule of Benefits, for each visit the Plan Participant makes to a Hospital or Allied Health Facility for Emergency Medical Services. The Emergency room Copayment is waived if the visit results in an Inpatient Hospital Admission to the same Facility as where the Emergency room is located. A Plan Participant must pay a Physician's Copayment for each visit the Plan Participant makes to a Physician's office for Emergency Medical Services. See the Hospital Benefits Article in this Benefit Plan for more information on Emergency Room Benefits.

L. Eyeglasses

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

M. Hearing Aids – Network Benefits Only

Benefits are available for hearing aids for covered Plan Participants age seventeen (17) and under. 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 Covered Service. The Plan may increase the Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge. A hearing aid shall mean a non-disposable device that is designed to optimize audibility and listening skills.

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

N. Hospice and Home Health Care

1. Hospice Care is a covered Benefit as shown in the Schedule of Benefits.
2. Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered, as shown in the Schedule of Benefits.
3. Benefits are not available for Hospice Care when Medicare Part A is primary to this Plan.
4. Benefits are not available for Home Health Care when Medicare Part B is primary to this Plan.

O. Interpreter Expenses for the Deaf and Hard of Hearing – Network Benefits Only

Services performed by an In-Network qualified interpreter/transliterater are covered at one-hundred percent (100%) of the allowable charge when the Plan Participant needs such services in connection with medical treatment or diagnostic consultations performed by a Physician or Allied Health Professional, if the services are required because of the Plan Participant's hearing impairment or his failure to understand or otherwise communicate in spoken language. Services rendered by a family member are not covered.

P. 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.

Q. Pain Management Programs

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

R. Permanent Sterilization Procedures

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

S. Prescription Drugs

Benefits are available for Prescription Drugs, as shown in the Schedule of Benefits. Prescription Drug Benefits are provided under the Hospital Benefits and Medical and Surgical Benefits Articles of this Plan, and under the pharmacy benefit program provided by OGB's Pharmacy Benefit Manager.

Prescription Drugs Covered Under Hospital Benefits and Medical and Surgical Benefits

1. Prescription Drugs dispensed during an Inpatient or Outpatient Hospital stay, or in an Ambulatory Surgical Center are payable under the Hospital Benefits.
2. Medically Necessary/non-Investigational Prescription Drugs requiring parenteral administration in a Physician's Office are payable under the Medical and Surgical Benefits.
3. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician's office are payable under the Medical and Surgical Benefits. Covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include but are not limited to intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration as determined by BCBSLA are covered under the medical benefit.

Certain Prescription Drugs require the Claims Administrator's Authorization before a Plan Participant receives the Prescription Drugs. Prescription Drugs requiring Prior Authorization, include, but are not limited to, growth hormones, anti-tumor necrosis factor drugs, intravenous immune globulins, interferons, monoclonal antibodies, and hyaluronic acid derivatives for joint injection.

The Plan Participant or his Physician should call the Customer Service number on the back of the ID card, or go to the Claims Administrator's website at www.bcbsla.com/ogb for the most current list of Prescription Drugs that require Prior Authorization. The Plan Participant is responsible for making sure his Provider obtains all required Authorizations for him before he receives the Prescription Drugs. The Claims Administrator may need the Plan Participant's Provider to submit medical or clinical information about the Plan Participant's condition.

The Plan Participant should refer to the Schedule of Benefits for additional information.

T. Prescription Drugs Covered Under Pharmacy Plan

Prescription Drugs in the Formulary obtained from a retail pharmacy or by mail order through OGB's Pharmacy Benefits Manager are payable under the OGB pharmacy benefit program. The Formulary and pertinent information about the PBM's handling of the pharmacy benefit program can be found on the OGB website or at <https://mp.medimpact.com/ogb> or by contacting MedImpact member services at 1-800-910-1831.

U. Sleep Studies

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

V. Telehealth Services

Benefits are available to You for the diagnosis, consultation, treatment, education, care management, patient selfmanagement, and caregiver support when You and your Provider are not physically located in the same place. Interaction between You and your Provider must be held by two-way video and audio transmissions simultaneously. Telehealth does not cover telephone calls, e-mail messages, or instant messages between You and your Provider, and must be medically appropriate for the setting in which the services are provided.

The amount You pay for a Telehealth visit may be different than the amount You would pay for the same Provider's service in a non-Telehealth setting. You will pay more for a Telehealth visit when your Provider is not in your Network.

W. Urgent Care Center

An Urgent Care Center Copayment, as shown in the Schedule of Benefits, applies to each visit to an Urgent Care Center that is in the Network. If a Plan Participant receives care from a Non-Network Urgent Care Center, the services are not covered on this Plan.

X. Vision Care

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

ARTICLE XV.

CARE MANAGEMENT

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

1. Selection of Provider

A Plan Participant may generally obtain medical care from any Provider. However, Benefits will be paid only when care is received from a Network Provider and the services have been Authorized as Medically Necessary before the services are rendered.

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

If a Plan Participant wants to receive services from a Non-Network Provider and obtain the highest level of Benefits, he must notify the Claims Administrator's Care Management Department before services are rendered. The Claims Administrator will approve the use of a Non-Network Provider only if the Claims

Administrator determines that the services cannot be provided by a Network Provider within a seventy-five (75) mile radius of the Plan Participant's home.

The Claims Administrator must approve the use of the Non-Network Provider and issue any required Authorization before services are rendered. If the Claims Administrator does not approve use of the Non-Network Provider and issue an Authorization prior to services being rendered, no Benefits will be paid and the Plan Participant will be responsible for all charges.

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.
- (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.

b. Outpatient Services, Other Covered Services and Supplies

- (1) If a Blue Cross Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.
- (2) If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable unless the procedure is deemed Medically Necessary. If the procedure is deemed Medically Necessary, the Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage. If the procedure is not deemed Medically Necessary, the Plan Participant is responsible for all charges incurred.

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.

B. Population Health – In Health: Blue Health

1. Qualification

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

2. Population Health Benefits

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

Through the In Health: Blue Health Services program, the health coach works with Plan Participants to help them learn the self-care techniques they will need in order to manage their chronic disease, establish realistic goals for lifestyle modification, and improve adherence to their Physician prescribed treatment plan. OGB and Blue Cross and Blue Shield of Louisiana are dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant. The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.

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

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

C. Case Management - In Health: Blue Touch

1. Case Management (CM) is the managed care available in cases of illness or injury where critical care is required and/or treatment of extended duration is anticipated. The Plan Participant may qualify for Case Management services at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.
2. Case Management may provide coverage for services that are not normally covered. To be eligible, the illness or injury must be a covered condition under the Plan, and Case Management must be approved prior to the rendering of services and/or treatment.
3. The role of Case Management is to service the Plan Participant by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.
4. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Case Management services will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant. The provision of Case Management services to one Plan Participant will not entitle any other Plan Participant to Case Management services or be construed as a waiver of the Claims Administrator's right, to administer and enforce this Plan in accordance with its express terms.
5. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Case Management services. Benefits for services and/or treatment approved by the Case Management are subject to the Deductible, Coinsurance and Allowable Charge.
6. The Plan Participant's Case Management services will be terminated upon any of the following occurrences:
 - a. The Claims Administrator determines that the Plan Participant is no longer a suitable candidate for the Case Management services, or that the Case Management services are no longer necessary.
 - b. The short and long-term goals established in the Case Management plan have been achieved, or the Plan Participant elects not to participate in the Case Management program.
7. Mental Health and Substance Use Disorder treatments/conditions are not eligible for Case Management.
8. The Claims Administrator must be the primary carrier at the time of enrollment in Case Management.
9. The Plan Participant may not be confined in any type of nursing home setting at the time of enrollment in Case Management.

D. Alternative Benefits

1. The Plan Participant may qualify for Alternative Benefits, at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. Case

Management may provide coverage for services that are not normally covered. To be eligible, the illness or injury must be a covered condition under the Plan. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Plan Participant and to the Group.

2. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Alternative Benefits will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant; nor will the provision of Alternative Benefits to a Plan Participant entitle any other Plan Participant to Alternative Benefits or be construed as a waiver of the Claims Administrator's right, to administer and enforce this 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 Plan.
5. The Plan Participant's Alternative Benefits will be terminated upon any of the following occurrences:
 - a. The Claims Administrator determines, in their sole discretion, that the Plan Participant is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.
 - b. The Plan Participant receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by the Claims Administrator.
6. The Claims Administrator must be the primary carrier at the time of request for Alternative Benefits.

ARTICLE XVI.

LIMITATIONS AND EXCLUSIONS

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

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. Medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.
3. Diagnostic or treatment measures that are Investigational or not recognized as generally accepted medical practice.
4. Services, Surgery, supplies, treatment, or expenses of a covered Plan Participant related to:
 - a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or as required by law;
 - b. Pre-implantation genetic diagnosis;
 - c. Preconception carrier screening; and
 - d. Prenatal carrier screening except screenings for cystic fibrosis.
5. Services and supplies for the treatment of and/or related to gender dysphoria.
6. Services rendered 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 healthcare Provider who is not licensed in the state where such services are rendered or in any facility not holding a valid license in the state and for the services rendered.
8. Facility fees for services rendered in a Physician's office or in any facility not approved by the federal Health Care Finance Administration for Medicare reimbursement.
9. Charges to obtain medical records or any other information needed and/or required to adjudicate a claim.
10. Charges greater than the global allowance for any laboratory, pathology or radiological procedure.
11. Any charges exceeding the Allowable Charge except as specifically agreed in writing by the Claims Administrator and the Plan Administrator.
12. Services, Surgery, supplies, treatment, or expenses:
 - a. other than those specifically listed as covered by this Benefit Plan or for which a Plan Participant has no obligation to pay, or for which no charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the State of Louisiana or any of its political subdivisions;

- b. rendered or furnished before the Plan Participant's Effective Date or after Plan Participant's coverage terminates;
 - c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license;
 - d. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with the Claims Administrator's policies and procedures for such determinations.
13. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services, except as specifically provided in this Benefit Plan.
14. Office-based Telehealth services including the delivery of healthcare, diagnosis, consultation, or treatment of a Plan Participant by a Non-Network Provider. Telephone calls, e-mail messages, or instant messages between a Physician or Nurse Practitioner in Our Network and a Plan Participant are not Covered Services. Services billed with Telehealth Services codes not medically appropriate for the setting in which the services are provided.
15. 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.
16. Any incidental procedure, unbundled procedure or mutually exclusive procedure, except as described in this Benefit Plan.
17. 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. sensory integration therapy
18. Services provided at a free-standing or Hospital based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
- a. Has not been actively involved in the Plan Participant's medical care prior to ordering the service, or
 - b. Is not actively involved in the Plan Participant's care after the service is received.

This exclusion does not apply to mammography testing.

19. Travel or transportation expenses, even though prescribed by a Physician.

20. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
 - a. Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
 - b. Related to judicial or administrative proceedings or orders.
 - c. Conducted for purposes of medical research.
 - d. Required to obtain or maintain a license of any type.
21. 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.
22. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.
23. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
24. Any charge for services, supplies or equipment advertised by the provider as free.
25. 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 Surgery Services as specifically provided in this Benefit Plan;
 - e. implantation of breast implants and services, except for Breast Reconstruction Surgery 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 (other than for Plan Participants in a program approved by the Plan Administrator);

- b. removal of excess fat or skin or services at a health spa or similar facility; or
- c. obesity or morbid obesity regardless of Medical Necessity, except as required by law

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.
- 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 healthcare 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

1. 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.
2. Services in the following categories:
 - a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
 - b. those for treatment of any Plan Participant confined in a prison, jail, or other penal institution; or
 - c. Health services for treatment of military service related disabilities, when the Plan Participant is legally entitled to other coverage and facilities are reasonably available.

E. DENTAL/VISION/HEARING

1. Dental and orthodontic services, appliances, supplies, and devices, including, but not limited to the following:
 - a. Dental braces and orthodontic appliances, except as specifically provided in this Benefit Plan;
 - b. Treatment of periodontal disease;

- c. Dentures, dental implants, and any surgery for their use, except if needed as the result of an accident that meets this Benefit Plan's requirements;
 - d. Treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in this Benefit Plan;
 - e. Expenses incurred for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, as specifically set forth herein, dental procedures which fall under the guidelines of treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral maxillofacial surgeries which are shown to the satisfaction of the Claim's Administrator to be Medically Necessary, non-dental, non-cosmetic procedures.
2. Diagnosis, treatment or surgery of dentofacial anomalies including but not limited to, malocclusion, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition, except as specifically provided in this Benefit Plan.
 3. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - a. Extraction, restoration and replacement of teeth
 - b. Medical or surgical treatments of dental conditions
 - c. Services to improve dental clinical outcomes.
 4. Dental implants.
 5. Dental braces.
 6. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
 - a. Transplant preparation
 - b. Initiation of immunosuppressives
 - c. The direct treatment of acute traumatic Injury, cancer or cleft palate
 - d. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.
 7. 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. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
10. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.
11. Oral appliances for snoring.
12. Medical supplies not specifically provided for in this Benefit Plan.

G. REPRODUCTIVE/FERTILITY

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

6. Prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.
7. Paternity tests and tests performed for legal purposes.

H. HABILITATIVE

1. Services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, and dietary or educational instruction for all diseases and/or illnesses, except diabetes.
2. Marriage counseling, family relations counseling, divorce counseling, parental counseling, pastoral counseling, job counseling and career counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.
3. Services of a licensed speech therapist when services are not prescribed by a Physician and prior authorization is not obtained.
4. Services of a licensed speech therapist when services are provided for any condition, except for the following: restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injuries, or other similar structural or neurological disease and autism spectrum disorders.
5. Services, surgery, supplies, treatment or expenses for the following REGARDLESS OF CLAIM OF MEDICAL NECESSITY:
 - a. biofeedback;
 - b. lifestyle/habit changing clinics and/or programs except services required to be covered by law;
 - 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, etc., except services required to be covered by law;
 - 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 includes Applied Behavior Analysis (ABA) services that are not rehabilitative treatment and specifically target academic and/or educational goals, and para-professional or shadowing services utilized as maintenance and/or Custodial Care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law.
7. Sleep studies, unless performed as a home sleep study or performed in a Network-accredited sleep laboratory. If a sleep study is not performed in a Network-accredited sleep laboratory, as a home sleep study or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.
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 licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

9. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
10. Tuition for or services that are school-based for Children and adolescents under the Individuals with Disabilities Education Act.
11. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
12. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

I. ORGAN TRANSPLANT

1. Services, Surgery, supplies, treatment or expenses related to:
 - a. any costs of donating an organ or tissue for transplant when a Plan Participant is a donor except as provided in this Benefit Plan;
 - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high dose chemotherapy to support transplant procedures;
 - c. the transplant of any non-human organ or tissue except as approved by the Claims Administrator (porcine valve); or
 - d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.
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) unless required by law.
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 Benefit 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.
4. Prescription Drug products that contain marijuana, including medical marijuana.

K. MENTAL HEALTH/SUBSTANCE USE DISORDER

1. Methadone treatment as maintenance, L.A.A.M. (1-Alpha- Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
2. Substance Use Disorder Services for the treatment of caffeine use.

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

ARTICLE XVII.

COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits (“COB”) section applies to This Plan when a Member has healthcare coverage under more than one Plan. “Plan” and “This Plan” are defined below.
2. This Section is intended to describe whether the Benefits of This Plan are determined before or after those of another Plan when this Section applies.

The Benefits of This Plan:

- a. will not be reduced when, under the terms of this Section and any applicable laws, This Plan determines its Benefits before another Plan.
- b. may be reduced when under the terms of this Section or any applicable laws, another Plan determines its benefits first. That reduction is described in Subsection D of this Section, “When This Plan is Secondary.”

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

1. “Allowable Expense” means any healthcare expense, including coinsurance or copayments, and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.
 - a. If a Plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan’s deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.
 - b. An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.
 - c. Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.
 - d. The following are examples of expenses that are not Allowable Expenses.
 - (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
 - (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.
 - (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan’s payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan’s payment arrangement and if the Provider’s contract permits, that negotiated fee or payment shall be the Allowable Expense used by the secondary plan to determine its benefits.

2. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.
3. "Claim" refers to a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:
 - a. services (including supplies);
 - b. payment for all or a portion of the expenses incurred;
 - c. a combination of prongs a and b of this Subparagraph; or
 - d. an indemnification.
4. "Claim Determination Period or Plan Year" refers to a period of not less than 12 consecutive months over which Allowable Expenses shall be compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each Plan will pay or provide.
 - a. The Claim Determination Period is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group or individual contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.
 - b. As each claim is submitted, each Plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.
5. "Closed Panel Plan" refers to a Plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.
6. "Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA" refers to coverage provided under a right of continuation pursuant to federal law.
7. "Coordination of Benefits or COB" refers to a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable Expenses.
8. "Custodial Parent"
 - a. the parent awarded custody of a child by a court decree; or
 - b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
9. "Group Insurance Contract" means an insurance policy or coverage that is sold in the group market and that are usually sponsored by a person's employer, union, employer organization or employee organization.
10. "Group-Type Contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type Contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.
11. "High-Deductible Health Plan" has the meaning given the term under section 223 of the *Internal Revenue Code* of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

12. "Hospital Indemnity Benefits" are benefits not related to expenses incurred. Hospital indemnity benefits does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
13. "Individual Insurance Contract" means an insurance policy or coverage that is sold to an individual and/or his/her family in the individual market.
14. "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its Benefit Plan shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the Benefit Plan uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this Subsection.
 - a. Plan includes:
 - (1) Group Insurance Contracts, Individual Insurance Contracts and Subscriber contracts;
 - (2) Uninsured arrangements of group or Group-Type coverage;
 - (3) Group and non-group coverage through closed panel plans;
 - (4) Group-Type Contracts;
 - (5) The medical care components of long-term care contracts, such as skilled nursing care;
 - (6) The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;
 - (7) Medicare or other governmental benefits, as permitted by law, except as provided in Subparagraph b of this definition. That part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program; and
 - (8) Group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
 - b. Plan does not include:
 - (1) Hospital indemnity coverage benefits or other fixed indemnity coverage;
 - (2) Accident only coverage;
 - (3) Specified disease or specified accident coverage;
 - (4) Limited benefit health coverage as defined in La. R.S. 22:47(2)(c), except for group and non-group dental coverage;
 - (5) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;
 - (6) Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
 - (7) Medicare supplement policies;

(8) A state plan under Medicaid; or

(9) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

15. "Policyholder or Subscriber" means the primary insured named in an Individual Insurance Contract.

16. "Primary Plan" means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration.

A Plan is a Primary Plan if:

a. the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

b. all plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

17. "Provider" means a healthcare professional or healthcare facility.

18. "Secondary Plan" means a Plan that is not a Primary Plan.

19. "This Plan" means the part of this Benefit Plan and any amendments/endorsements thereto that provides Benefits for healthcare expenses.

C. Order of Benefit Determination Rules

1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

(1) Except as provided in Paragraph ii below, a Plan that does not contain a coordination of benefits provision that is consistent with this Section is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

b. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

c. When a person is covered under a group Plan and a non-group (individual) Plan, the non-group Plan is always secondary to any group Plan, disregarding any other provision of this Section.

2. The following rules apply when group Plans coordinate benefits among themselves, and when non-group ("individual") Plans coordinate benefits among themselves. Each Plan determines its order of benefits **using the first of the following rules that applies, and discarding any other successive rules:**

a. Non-Dependent or Dependent Rule. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, Subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired

employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

- b. Dependent Child Covered Under More Than One Plan Rule. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
- (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (a) The Plan of the parent whose Birthday falls earlier in the calendar year is the Primary plan; or
 - (b) If both parents have the same Birthday, the Plan that has covered the parent the longest is the Primary plan.
 - (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - (b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits;
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits; or
 - (4) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial parent;
 - (b) The Plan covering the Spouse of the Custodial parent;
 - (c) The Plan covering the non-custodial parent; and the
 - (d) The Plan covering the Spouse of the non-custodial parent.
 - (5) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraphs (2)(b)(1) or (2)(b)(2) above shall determine the order of benefits as if those individuals were the parents of the child.
 - (6) For a dependent child covered under the Spouse's plan:
 - (a) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a Spouse's plan, the rule in Subparagraph (2)(e) (Longer or Shorter Length in Coverage) applies.
 - (b) In the event the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule above in Subparagraph (2)(b)(1) to the dependent child's parent(s) and the dependent's Spouse.

- c. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) can determine the order of benefits.
- d. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) determine the order of benefits.
- e. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an employee, member, policyholder, Subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

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

The start of a new Plan does not include:

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

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

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

D. When this Plan is Secondary

Whenever This Plan is secondary to any other Plan, the Benefits of This Plan may be reduced so that no more than the Allowable Expense is ever paid for any given Claim taking into account all the benefits payable to the Member under all his/her Plans and sum of the Allowable Expenses for any Claim Determination Period. This will apply whether or not a Claim is made. The Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the Benefits of This Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of This Plan.

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

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

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. The Plan 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 XVIII. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP AND ALL PLAN PARTICIPANTS. THE GROUP IS THE PLAN ADMINISTRATOR FOR THIS 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 the Claims Administrator liable or responsible for any duty or obligation that is imposed on the Employer by federal or state law or regulations. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Plan Participant for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions), or in the case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition. To the extent that this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group's failure to do so.
2. The 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 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 the Plan Participant's care or treatment.
3. The Plan Administrator shall administer the 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 Plan Participant's rights, and to decide questions of plan interpretation and those of fact relating to the plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

4. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, healthcare providers, or other third parties relative to this 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 its subsidiaries, affiliates, subcontractors, or designees.
5. The Claims Administrator will not discriminate on the basis of race, color, religion, national origin, disability, sex, gender identity, sexual orientation, age, protected veteran or disabled status or genetic information in its administration of the Benefit Plan.
6. The Plan Administrator will not discriminate on the basis of race, color, religion, national origin, disability, sex, age, protected veteran or disabled status or genetic information; and shall not impose eligibility rules or variations in premium based on a Plan Participant's health status or a health status-related factor.

B. Amending and Terminating the 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 or other benefit-eligible employment. The Retiree shall be placed in the Rehired Retiree category for premium calculation. The Rehired Retiree premium classification applies to Retirees with and without Medicare. The premium rates applicable to the Rehired 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 Plan

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

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

E. Benefits to Which Plan Participants Are Entitled

1. 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 Plan and regularly included in such Provider's charges.
2. If the Plan Participant is an Inpatient in a Hospital on the date coverage ends, medical Benefits in connection with the Admission for that patient will end at the end of that Admission, or upon reaching any Benefit limitations set in this Benefit Plan, whichever occurs first. No Benefits are available to a Plan Participant for Covered Services rendered after the date of termination of a Plan Participant's coverage.

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 fully insured 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 the Plan Participant was insured under this Plan. The Claims Administrator 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 with 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 their Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. The Prescription Drug Claim Form may require the signature of the dispensing pharmacist. The Claim form should then be sent to OGB's Pharmacy Benefit Manager, whose telephone number should 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 for Covered Services that the Plan Participant receives. The Claims Administrator is not liable for any act or omission of any Provider, or for any Claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any Network Provider or in any Network Provider's facilities. The Claims Administrator has no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.
3. The use or non-use of an adjective such as Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

K. This Benefit Plan and Medicare

When an individual is covered by this Plan and by Medicare, Medicare laws and regulations govern the order of Benefit, that is, whether Medicare is the primary or secondary payer.

1. The following applies to Retirees and to covered Spouses of Retirees who have attained the age of sixty-five (65) **before** July 1, 2005:
 - a. If the Plan Participant is not enrolled in Medicare, this Plan is the primary payer. Eligible Expenses will be paid without regard to Medicare coverage.
 - b. If the Plan Participant is enrolled in Medicare, Medicare is the primary payer. Eligible Expenses under this Plan will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. Eligible Expenses not covered by Medicare are payable.
2. The following applies to Retirees and to covered Spouses of Retirees who attain or have attained the age of sixty-five (65) **on or after** July 1, 2005:
 - a. Eligible for Medicare

A Retiree or Spouse of a Retiree who attains or has attained age sixty-five (65), when either has sufficient earnings credits to be eligible for Medicare, **MUST ENROLL** in Medicare Part A and Medicare Part B in order to receive Benefits under this Plan.

Benefits are payable as secondary to the Part of Medicare in which the individual is enrolled, except as specifically provided in this Benefit Plan. Eligible Expenses under this Plan will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. All provisions of this Plan, including all provisions related to Deductibles, Coinsurance, limitations and exclusions will be applied.

If such Retiree or Spouse of a Retiree is not enrolled in Medicare Part A and Medicare Part B, **NO BENEFITS** will be paid or payable under this Plan except Benefits payable as secondary to the Part of Medicare in which the individual is enrolled;

b. Not Eligible for Medicare

A Retiree and Spouse of a Retiree who do not have sufficient earnings credits to be eligible for Medicare, and therefore are not enrolled in Medicare, must provide written verification from the Social Security Administration or its successor.

This Plan is the primary payer, and Benefits will be paid without regard to Medicare coverage.

L. Notices

Any notice required under this Benefit Plan must be in writing. Any notice required to be given to the 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 the Plan Participant may, by written notice, indicate a new address for giving notice.

M. 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).

N. 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 Plan, any amounts the Plan Participant or Provider owes the Plan.

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

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

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

P. 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 Administrator. 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 this claims administration agreement.

Q. Out-of-Area Services

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

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

The Magnolia Local Plus Benefit Plan covers only limited healthcare services received outside of Blue Cross and Blue Shield of Louisiana's service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care obtained outside the geographic area the Claims Administrator serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

Inter-Plan Arrangements Eligibility – Claim Types

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

1. BlueCard® Program

Under the BlueCard® Program, when Plan Participants access covered healthcare services within the geographic area served by a Host Blue, 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 Network Providers.

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

- the billed covered charges for Your Covered Services; or
- 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 Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

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

2. Non-Participating Providers Outside Blue Cross and Blue Shield of Louisiana’s Service Area

a. Plan Participant Liability Calculation

When Covered Services are provided outside of Blue Cross and Blue Shield of Louisiana’s service area by Non-Participating Providers, the amount You pay for such services will normally be based on either the Host Blue’s Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Medical Services.

b. Exceptions

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

3. Blue Cross Blue Shield Global Core

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

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

a. Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global Core service center for assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global

Core service center to begin Claims processing. However, if You paid in full at the time of service, You must submit a Claim to receive reimbursement for Covered Services. You must contact the Claims Administrator to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

b. Outpatient Services

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

c. Submitting a Blue Cross Blue Shield Global Core Claim

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

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

3. Authorized Workforce Members

The Plan shall disclose Protected Health Information only to members of the Plan Administrator's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan.

For purposes of this HIPAA Privacy section, "members of the Plan Administrator's workforce" shall refer to all workforce members and other persons under the control of the Plan Administrator.

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

- a. Updates Required. The Plan Administrator shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
- b. Use and Disclosure Restricted. An authorized 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 Participant'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 Participant Employer/Plan Sponsor

The Participant Employer agrees to:

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

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

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.

U. Value-Added Programs

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

ARTICLE XIX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

OGB Eligibility Appeal Process

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

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 Us or with Provider services. A quality of service concern addresses appropriateness of care given to a Member, Our services, access, availability or attitude and those of Our Network Providers.

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

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

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

C. Appeals: Standard Appeal, External and Expedited Appeals

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

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

Standard Appeals Process

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

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

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

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

Administrative Appeals

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

1. First Level Administrative Appeal

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

The Claims Administrator will investigate the Plan Participant's concerns. If the administrative Appeal is denied, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

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

All Administrative Appeals should be submitted in writing to:

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

2. Second Level Administrative Appeal

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

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

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

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

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

3. OGB Voluntary Level Appeal

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

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

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

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

Medical Appeals

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

All Medical Appeals should be submitted in writing to:

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

1. First Level Internal Medical Appeals

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

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

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

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

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

2. Second Level Medical / External Appeals

If the Plan Participant is not satisfied with the determination on his Claim, or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative must send a written request for an external Appeal, conducted by a non-affiliated Independent Review Organization (IRO), within **one hundred twenty (120) calendar days** from receipt of the internal Appeal decision, to:

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

Requests submitted to the Claims Administrator after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered. The Plan Participant is required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. **Appeals submitted by your Provider will not be accepted without this form completed with Your signature.**

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

any further action by the Plan Participant or his Authorized Representative within one (1) business day after completing the preliminary review.

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

The IRO decision will be considered final and binding.

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

Expedited Appeals Process

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

An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

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

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

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

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

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

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

1. Expedited Internal Medical Appeals

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

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

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

2. Expedited External Medical Appeal

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

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

Any and all lawsuits, other than those related to claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

ARTICLE XX. **OBTAINING CARE WHILE TRAVELING, MAKING POLICY CHANGES AND FILING CLAIMS**

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

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

- a. In an Emergency, go directly to the nearest Hospital.
- b. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest PPO Network Providers.
- c. Use a designated PPO Network 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 professional Providers and seek reimbursement).
- e. The Plan Participant must obtain any required Authorizations from the Claims Administrator.

B. How to File Insurance Claims

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 them 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 ID card shows the name of the Employee or Retiree as it appears on the Claims Administrator's records. The ID card also lists the Plan Participant's Benefit Plan number (ID #). This number is the identification to the Plan Participant's membership records and should be provided to the Claims Administrator each time a Claim is filed. To assist in promptly handling the Plan Participant's Claims, the Plan Participant must be sure that the appropriate Claim form is used, and includes the following:

1. Full name of patient
2. Plan Participant ID number, as shown on the ID card
3. Patient's date of birth
4. Patient's relationship to the Employee
5. All services 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
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. Additional Information for Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

When the Plan Participant is admitted to a Network Hospital or Allied Health Facility, the Plan Participant should show their Blue Cross and Blue Shield ID card to the admitting clerk. The Provider will file the Claim with the Claims Administrator. The Plan's payments will go directly to the Network Provider. The Provider will then bill the Plan Participant directly for any remaining balance. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

2. Outpatient Department Claims

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

3. Emergency Room Claims

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

4. Durable Medical Equipment (DME) Claims

Charges for rental or purchase of wheelchairs, braces, crutches, etc. must be on the bill of the supplying firm with 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 Use Disorder Claims

For help with filing a Claim for Mental Health and/or Substance Use Disorder, 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., the Plan Participant 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 should 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. call 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 the Plan Participant Has a Question About a Claim

If the Plan Participant has a question about the processing or payment of a Claim, the Plan Participant can write to the Claims Administrator at the address below or the Plan Participant may call the Claim Administrator's customer service department at the 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 they have pertinent information at hand, particularly the Benefit Plan 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 70898-9917

Remember, the Plan Participant should ALWAYS refer to their Benefit Plan number in all correspondence and recheck it against the Benefit Plan 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, Monroe and Shreveport.

ARTICLE XXI. RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator Responsibility

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

B. Amendments to or Termination of the Plan

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

C. Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to the Plan Participant), 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: Health Plan for State of Louisiana Employees and Retirees

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

(800) 272-8451

PLAN NUMBER (PN): 501

TYPE OF PLAN: Group Major Medical Benefit Plan

TYPE 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 retained 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. 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 OF COVERAGE RIGHTS UNDER COBRA**

Introduction

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

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

What is COBRA Coverage?

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

Who is entitled to elect COBRA Coverage?

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

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

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

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

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

- The parent-Employee dies;

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

When is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries only after the Office of 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. You must follow the notice procedures specified by the Office of Group Benefits. If notice is not provided to the Office of Group Benefits during the 60-day notice period, ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

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

Electing COBRA

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

How Long Does COBRA Coverage Last?

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

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

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

Extension of COBRA Coverage

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

Disability extension of COBRA coverage

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

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

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

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

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

Second qualifying event extension of COBRA coverage

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

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

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

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

More Information About Individuals Who May Be Qualified Beneficiaries

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

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

Alternate recipients under QMCSOs

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

Health Insurance Marketplace

There may be other coverage options for you and your family. Through the Affordable Care Act, You are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and Out-of-Pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity with another group health plan for which you are eligible (such as a Spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

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

COBRA Information: Discovery Benefits, Inc.
P.O. Box 2079
Omaha, NE 68103-2079
1.866.451.3399
1.855.678.1733 (fax)

Notice Procedures

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

Notices Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this notice, and you may obtain copies from the COBRA Administrator without charge or download them at www.discoverybenefits.com). 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:

Discovery Benefits, Inc.
P.O. Box 2079
Omaha, NE 68103-2079
1.855.678.1733 (Fax)

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

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

Notice Procedures (continued)

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

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

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

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



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

Nondiscrimination Notice

Discrimination is Against the Law

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

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

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

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

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

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

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

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

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

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

Or

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

NOTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

