



**OFFICE OF GROUP BENEFITS
PPO PLAN FOR
STATE OF LOUISIANA
EMPLOYEES & RETIREES**

provided by



**BlueCross BlueShield
of Louisiana**

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

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



**NON-GRANDFATHERED GROUPCARE
HEALTH BENEFIT PLAN**

NOTICE

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

Specific information about In-Network and Out-of-Network facility-based physicians can be found at www.bcbsla.com or by calling the customer service telephone number on the back of Your identification (ID) card.

Your share of the payment for health care services may be based on the agreement between Your health plan and Your Provider. Under certain circumstances, this agreement may allow Your Provider to bill You for amounts up to the Provider's regular billed charges.

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

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

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

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

PPO SCHEDULE OF BENEFITS

Eligible Expenses are reimbursed in accordance with a Fee Schedule of maximum allowable charges.

ALL ELIGIBLE EXPENSES ARE DETERMINED IN ACCORDANCE WITH PLAN LIMITATIONS AND EXCLUSIONS.

COMPREHENSIVE MEDICAL BENEFITS

DEDUCTIBLES

Inpatient deductible per day, maximum of five days per admission\$50.00 per Day
(Waived for admissions to Network Preferred hospitals.)

Emergency Room Charges for each visit, unless the Plan Participant is hospitalized immediately following emergency room treatment \$150.00
(Prior to and in addition to Plan Year Deductible.)

Professional and other Eligible Expenses, Active Employees and Dependents of Active Employees per Plan Year \$500 per Plan Participant

Professional and other Eligible Expenses, Retirees and Dependents of Retirees per Plan Year \$300 Per Plan Participant

Family Unit Maximum 3 Individual Deductibles

PERCENTAGE PAYABLE AFTER SATISFACTION OF APPLICABLE DEDUCTIBLES

Eligible Expenses incurred for services of a Network Preferred Provider 90%

Eligible Expenses incurred for services of a Non-Network/All Other Providers..... 70%

Eligible Expenses incurred when Medicare or other group health plan is primary, after Medicare deduction.....0%

Eligible Expenses in excess of \$10,000 per Plan Year, per Plan Participant 100%

- Eligible Expenses of a PPO are based upon contracted rates. PPO discounts are not Eligible Expenses and do not apply to the \$10,000 threshold.
- Eligible Expenses of Non-Network/All Other Providers are based upon the OGB's Fee Schedule. Charges in excess of the Fee Schedule are not Eligible Expenses and do not apply to the \$10,000 threshold.

There may be a significant out-of-pocket expense to the Plan Member when using a Non-Network Provider.

DENTAL SURGERY BENEFIT FOR SPECIFIED PROCEDURE

Percentage Payable (Not subject to Plan Year deductible) 100%

PRESCRIPTION DRUGS (Not subject to deductible)

Network Pharmacy Member pays 50% of drug costs at point of purchase

Maximum Co-payment \$50 per 31-day Prescription dispensed

Out-of-pocket threshold.....\$1,200 per Person, per Plan Year

Co-payment after threshold is reached Brand – \$15, Generic – \$0
(Plan pays balance of Eligible Expenses)

Non-network Pharmacy Member pays full drug costs at point of purchase

In-State Reimbursement limited to 50% of amount payable
by Plan at Network Pharmacy

Out-of-State Reimbursement limited to 80% of amount payable
by Plan at Network Pharmacy

Note: Beginning January 1, 2006, a new Medicare prescription drug plan became available to all Medicare recipients. OGB’s Plan coverage provides benefits that are on average as good as or better than Medicare Part D.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage.

PREVENTIVE CARE

Preventive Care Services rendered by Network Preferred Providers are reimbursed at 100% of Eligible Expenses, as provided in the Affordable care Act;

Services include screenings to detect illness or health risks during a Physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history.

Specialized age appropriate wellness – For a complete list of benefits, see the Preventive or Wellness Care Article of this Benefit Plan.

DURABLE MEDICAL EQUIPMENT

Percentage Payable See percentage payable after deductible – Page 4.

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Deductible

Subject to and combined with the Medical Deductibles set forth above.

Percentage of Eligible Expenses Payable after Satisfaction of Deductibles

	Network Preferred Providers	Non-Network/ All Other Providers
Inpatient Treatment (Prior Authorization Required)	90%	70%
Outpatient Treatment	90%	70%

PREFERRED PROVIDER ORGANIZATION (PPO)

COMPREHENSIVE MEDICAL BENEFIT PLAN

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

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

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

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

Except for necessary technical terms, common words are used to describe the Benefits provided under this Benefit Plan. "We," "Us" and "Our" means BLUE CROSS AND BLUE SHIELD OF LOUISIANA. "You," "Your," and "Yourself" means the Plan Participant and/or enrolled Dependent. Capitalized words are defined terms in Article II - "Definitions." A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

FACTS ABOUT THIS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

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

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

Most Benefits are subject to the Plan Participant's payment of a Deductible as stated in the Schedule of Benefits. After payment of applicable Deductibles, Benefits are subject to two (2) Coinsurance levels (for example: 90/10, 70/30). The Plan Participant's choice of a Provider determines what Coinsurance level applies to the service provided. The Plan will pay the highest Coinsurance level for Medically Necessary services when a Plan Participant obtains care from a Preferred Network Provider. The Plan will pay the lower Coinsurance level when a Plan Participant obtains Medically Necessary services from a Provider who is not in the Preferred Network.

CLAIMS ADMINISTRATOR'S PREFERRED PROVIDER NETWORK

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

The Preferred Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with the Claims Administrator to participate in the Blue Cross and Blue Shield of Louisiana Preferred Provider Network and render services to the Plan Participants.

These Providers are called "Preferred Network Providers." Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's dental network.

To obtain the highest level of Benefits available, the Plan Participant should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Network Provider before the service is

rendered. Plan Participants may review a current paper Provider directory, check on-line at www.bcbsla.com, or contact the Plan's customer service department at the number listed on their ID card.

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

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

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

RECEIVING CARE OUTSIDE THE PREFERRED NETWORK

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

The Plan pays a lower level of Benefits when a Plan Participant uses a Provider outside the Preferred Network. Benefits may be based on a lower Allowable Charge, and/or a penalty may apply. Care obtained outside the Claims Administrator's network means the Plan Participant has higher Out-of-Pocket costs and pays a higher Copayment, Deductible, and/or Coinsurance than if he had stayed In-Network. THESE ADDITIONAL COSTS MAY BE SIGNIFICANT. In addition, the Plan only pays a portion of those charges and it is the Plan Participant's responsibility to pay the remainder. The amount the Plan Participant is required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum.

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

AUTHORIZATIONS

Some services and supplies require Authorization from the Claims Administrator before services are obtained. Your Schedule of Benefits lists the services, supplies, and prescription drugs that require this advance Authorization.

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

HOW THE PLAN DETERMINES WHAT IS PAID FOR COVERED SERVICES

When a Plan Participant Uses Preferred Network Providers

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

When a Plan Participant Uses Participating Providers

Participating Providers are Providers who have signed contracts with the Claims Administrator or another Blue Cross and Blue Shield plan for other than the Preferred Network. These Providers have agreed to accept the lesser of billed charges or the negotiated amount as payment in full for Covered Services provided to the Plan Participant. This amount is the Participating Provider's Allowable Charge. When a Plan Participant uses a Participating Provider, this Allowable Charge is used to determine the amount the Plan pays for Medically Necessary Covered Services and the amount the Plan Participant pays.

When a Plan Participant Uses Non-Participating Providers

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

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

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

SAMPLE ILLUSTRATION OF PLAN PARTICIPANT COSTS WHEN USING A NON-PARTICIPATING HOSPITAL

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

EXAMPLE: A Plan Participant has a PPO plan with a \$500 Deductible Amount. The Plan Participant has 90/10 Coinsurance when he receives Covered Services from Hospitals in the Preferred Network and 70/30 Coinsurance when he receives Covered Services from Hospitals that are not in the Preferred Network. Assume the Plan Participant goes to the Hospital, has previously met his Deductible, and has obtained the necessary Authorizations prior to receiving a non-emergency service. The Provider's billed charge for the Covered Services is \$12,000. The Company negotiated an Allowable Charge of \$2,500 with its Preferred

Network Hospitals to render this service. The Allowable Charge of Participating Providers is \$3,000 to render this service. There is no negotiated rate with the Non-Participating Hospital.

The Plan Participant receives Covered Services from:	Preferred Network Provider Hospital	Participating Provider Hospital	Non-Participating Provider Hospital
Provider's Bill:	\$12,000	\$12,000	\$12,000
Allowable Charge:	\$2,500	\$3,000	\$2,500
The Plan pays:	\$2,250 \$2,500 Allowable Charge x 90% Coinsurance = \$2,250	\$2,100 \$3,000 Allowable Charge x 70% Coinsurance = \$2,100	\$1,750 \$2,500 Allowable Charge x 70% Coinsurance = \$1,750
Plan Participant pays:	\$250 10% Coinsurance x \$2,500 Allowable Charge = \$250	\$900 30% Coinsurance x \$3,000 Allowable Charge = \$900	\$750 \$2,500 x 30% = \$750
Is Plan Participant billed up to the Provider's billed charge?	NO	NO	YES - \$9,500, for a total of:
Total Plan Participant Pays:	\$250	\$900	\$10,250

**WHEN A PLAN PARTICIPANT RECEIVES MENTAL HEALTH OR
SUBSTANCE ABUSE BENEFITS**

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

ASSIGNMENT

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

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

PLAN PARTICIPANT INCENTIVES

Sometimes the Plan offers coupons, discounts, or other incentives to encourage Plan Participants to participate in various such as pharmacy, wellness, or disease management. A Plan Participant may wish

to decide whether to participate after discussing such with their Physicians. These incentives are not Benefits and do not alter or affect Plan Participant Benefits.

The Plan offers Plan Participants a wide range of health management and wellness tools and resources. Plan Participants can use these tools to manage their personal accounts, create health records and access a host of online wellness interactive tools.

Plan Participants also have access to a comprehensive wellness that includes a personal health assessment and customized health report to assess any risks based on their history and habits. Exclusive discounts are also available to Plan Participants on some health services such as fitness club memberships, diet and weight control, vision and hearing care and more.

CUSTOMER SERVICE E-MAIL ADDRESS

The Claims Administrator has consolidated its customer service e-mails into a single, easy-to-read address: bcbsla.com/ogb. 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 and click on "I'm a State Employee" at the bottom of each web page.

HOW TO OBTAIN CARE USING BLUECARD® WHILE TRAVELING

THE PLAN PARTICIPANT'S ID CARD OFFERS CONVENIENT ACCESS TO HEALTH CARE OUTSIDE OF LOUISIANA. IF THE PLAN PARTICIPANT IS TRAVELING OR RESIDING OUTSIDE OF LOUISIANA AND NEEDS MEDICAL ATTENTION, PLEASE FOLLOW THESE STEPS:

- a. In an Emergency, go directly to the nearest Hospital.
- b. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest PPO doctors and Hospitals.
- c. Use a designated PPO Provider to receive Network Benefits.
- d. Present the Plan Participant's ID card to the doctor or Hospital, 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.

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

ARTICLE II.

DEFINITIONS

Accidental Injury – A condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, injuries caused by the act of chewing do not constitute an injury caused by external force.

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

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

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

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

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

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

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

Ambulance Service – Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

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

Annual Enrollment - A period of time, designated by the Group, during which a Employee and their eligible Dependents may enroll for Benefits under this Benefit Plan.

Annual Enrollment Period - Unless otherwise specified in the Schedule of Benefits, the Annual Enrollment Period means the enrollment period prior to the beginning of each Plan Year.

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

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

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

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 Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified.

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

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

Benefit Payment - Payment of Eligible Expenses due or owing by a Covered Person, after applicable deductibles, co-payments, and coinsurance, and subject to all limitations and exclusions, at the rate shown under Percentage Payable in the Schedule of Benefits.

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 established by the Group to provide Benefits for eligible Plan Participants.

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

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

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 Plan identifies as a Brand-Name product. The Plan classifies a Prescription Drug as a Brand-Name Drug based on a

nationally recognized pricing source, therefore all products identified as a "Brand Name" by the manufacturer or pharmacy may not be classified as a Brand-Name Drug by the Plan.

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

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

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

Claim – A 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 incurred as a result of the service or treatment rendered.

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

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

COBRA - The federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 with amendments.

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

responsibility. The Plan's percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

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

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

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

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

Congenital Anomaly – A condition existing at or from birth, which significantly interferes with normal bodily function. 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 palate.

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

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

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 (Copay) – The amount of charges for a Covered Service which a Plan Participant must pay. The Copayment may be collected directly by a Physician or an Optometrist, who is a Preferred Network Provider, from the Plan Participant at the time of service, as the Plan Participant's share of payment for Copayment Services rendered in the Physician's or Optometrist's office. If a Copayment applies to a Covered Service, the Benefit Period Deductible Amount and/or Coinsurance will be waived.

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

Covered Person – An active or retired Employee, his eligible Dependent, or any other individual eligible for coverage for whom the necessary application forms have been completed, for whom the required contribution has been made, and whom the Group has accepted Eligibility and enrolled into the Plan. The terms Covered Person, defined here are used interchangeably with the terms Plan Participant.

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

Creditable Coverage for HIPAA Portability - Prior coverage under an individual or group health plan including, but not limited to, Medicare, Medicaid, government plan, church plan, COBRA, military plan or state children's health insurance (e.g., LaCHIP). Creditable coverage does not include specific disease policies (i.e., cancer policies), supplemental coverage (i.e., Medicare Supplement) or limited benefits (i.e., accident only, disability insurance, liability insurance, workers' compensation, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics or coverage as specified in federal regulations under which benefits for medical care are secondary or incidental to the insurance benefits).

Custodial Care

1. Care designed to assist an individual in the performance of daily living activities (i.e. services which constitute personal care such as walking, getting in and out of bed, bathing, dressing, eating, and using the toilet) that does not require admission to a hospital or other institution for the treatment of a disease, illness, accident, or injury, or for the performance of surgery;
2. Care primarily intended to provide room and board to an individual with or without routine nursing care, training in personal hygiene, or other forms of self-care;
3. Supervisory care provided by a Physician whose patient is mentally or physically incapacitated and is not under specific medical, surgical, or psychiatric treatment, when such care is intended to reduce the patient's incapacity to the extent necessary to enable the patient to live outside of an institution providing medical care, or when, despite treatment, there is not a reasonable likelihood that the incapacity will be reduced.

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

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

Agency adoption – the date the adoption contract was executed between the Employee and the adoption agency;

Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee. The Plan Administrator must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;
 - c. Child for whom the Employee has legal custody or guardianship – the date of the court order granting legal custody or guardianship or of the notarized act granting provisional custody;
 - d. Grandchild of the Employee who is not in the legal custody of the Employee whose parent is a covered Dependent:
 - i. The date of birth of the Grandchild, if all of the above requirements are met at the time of birth; or
 - ii. The date on which the coverage becomes effective for the covered Dependent, if all of the above requirements are not met at the time of birth.

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

Deductible Amount

- A. Benefit Period Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Plan Participant must pay within a Benefit Period before the Plan starts paying Benefits. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits.
- B. Family Deductible Amount – For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Benefit Period Deductible Amount. However, no family Plan Participant may contribute more than the Benefit Period Deductible Amount to satisfy the maximum amount required of a family. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan.
- C. Family Unit Limit means that each of three covered members of a family unit has met the dollar amount shown in the Schedule of Benefits as Plan Year deductible for an individual. Once the Family Unit limit is met, the deductibles of all other covered members of the family unit will be considered satisfied for that Plan Year.
- D. Prescription Drug Deductible - The dollar amount, if shown in the Schedule of Benefits, which each Plan Participant must pay within a Benefit Period prior to paying a Prescription Drug Copayment. The Prescription Drug Deductible Amount does not accrue to the Benefit Period Deductible Amount or the Family Deductible Amount.

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

- A. represents himself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, 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, and (b) whose relationship to the Employee has been Documented, as defined herein:

- A. The covered Employee's legal Spouse;
- B. A Child from date acquired until attainment of age twenty-six (26);
- C. A Child of any age who meets the criteria set forth in the Eligibility Article of this Benefit Plan.

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures recognized by Plan as accepted medical practice, rendered because of specific symptoms, and which are

directed toward detection or monitoring of a definite condition, illness or injury. A Diagnostic Service must be ordered by a Provider prior to delivery of the service.

Disability - The Covered Person, if an Employee, 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, if a Dependent is prevented from substantially engaging in all the normal activities of a person of like age in good health solely because of a disease, illness, accident, or injury.

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

- A. The covered Employee's legal Spouse - Certified copy of certificate of marriage indicating date and place of marriage;
- B. Child:
 - a. Natural or legally adopted child of plan member - Certified copy of birth certificate listing plan member as parent or certified copy of legal acknowledgment of paternity signed by plan member or certified copy of adoption decree naming plan member as adoptive parent;
 - b. Stepchild - Certified copy of certificate of marriage to spouse and birth certificate listing spouse as natural or adoptive parent;
 - c. Child placed with your family for adoption by agency adoption or irrevocable act of surrender for private adoption - Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender;
 - d. Child for whom you have been granted guardianship or legal custody, including provisional custody, Certified copy of signed the court order granting legal guardianship or custody, or the original notarized act granting provisional custody in proper statutory form and substance;
 - e. Grandchild for whom you do not have legal custody or guardianship whose parent is a covered dependent - Certified birth certificate or adoption decree showing parent of grandchild is dependent child and certified copy of birth certificate showing dependent child is parent of grandchild;
- C. Child age 26 or older who is incapable of self-sustaining employment and who was covered prior to and upon attainment of age 26 - Documentation as described in 2a through 2d above together with an application for continued coverage supporting medical documentation prior to the child's attainment of age 26 as well as additional medical documentation of child's continuing condition periodically upon request by OGB;
- D. Such other written proof of relationship to the Employee deemed sufficient by 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. DME includes, but is not limited to, items such as wheelchairs, hospital beds, respirators, braces (non-dental), custom orthotics which must be specially made and not available at retail stores.

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

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

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

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

Emergency – See “Emergency Medical Condition.”

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

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

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

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

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

Expedited Appeal – Any request concerning an Admission, availability of care, continued Hospital stay, or health care service for a covered person or his authorized representative who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility.

Expedited External Appeal – A request for immediate review, by an Independent Review Organization (IRO), of an initial adverse determination, not to authorize continued services for Plan Participants currently in the Emergency room, under observation, or receiving Inpatient care.

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

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

Group – State of Louisiana Office of Group Benefits. or other legal entity of State of Louisiana Office of Group Benefits who is the Plan Administrator and sponsor of this Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

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

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

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

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

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

Independent Review Organization (IRO) – An independent review organization not affiliated with the Plan Administrator or Claims Administrator that conducts external reviews of final adverse 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 (1) year of unprotected intercourse.

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

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

Intensive Outpatients - Intensive outpatients 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 models include structured "crisis interventions," "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, 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, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
1. consultation with the Blue Cross and Blue Shield Association technology assessment (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.

Late Enrollee – An individual who enrolls in this Benefit Plan other than during the initial period in which he is eligible to enroll in this Benefit Plan or other than during any Special Enrollment period.

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 or Custodial Care.

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

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

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

Network Provider - A Provider that has signed an agreement with the Claims Administrator or another Blue Cross and Blue Shield plan to participate as a Plan Participant of the Preferred Care Provider Network or another Blue Plan's PPO Network.

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

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

Non-Network Provider - A Provider who is not a Plan Participant of the Preferred Care Network or another Blue Cross Blue Shield plan PPO Network.

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

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

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

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

Outpatient Surgical Facility - An ambulatory surgical facility licensed by the state in which services are rendered.

Overdue Applicant – An individual who enrolls in this Benefit Plan other than during the initial period in which he is eligible to enroll in this Benefit Plan or other than during any Special Enrollment period.

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

Partial Hospitalizations - These are defined as structured and medically supervised day, evening and/or night treatments. Services are provided to patients at least four (4) hours/day and are available at least three (3) days/week, although some patients may need to attend less often. The services are of essentially the same nature and intensity (including medical and nursing) as would be provided in a hospital except that the patient is in the hospital less than twenty-four (24) hours/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-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 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 – State of Louisiana Office of Group Benefits' medical Benefits plan for certain Employees of State of Louisiana Office of Group Benefits and is described in this document.

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

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

Plan Year - The period from January 1, or the date the Covered Person first becomes covered under the Plan, through December 31. Each successive Plan Year will be the twelve month period from January 1 through December 31.

Pre-Existing Condition – A physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period immediately prior to the Enrollment Date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

Pre-Existing Condition Exclusion Period – The time period, as specified in the Limitations and Exclusions Article of this Benefit Plan, during which services for a Pre-Existing Condition are not covered under this Benefit Plan.

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

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

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

Prescription Drug Deductible Amount – The dollar amount, if shown in the Schedule of Benefits, which must be paid by a Plan Participant or a family within a Benefit Period prior to any applicable Prescription Drug Copayment or Coinsurance percentage.

Preventive Services or Recommended Preventive Services - Under the Affordable Care Act this means:

- A. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. Recommendations of the United States Preventive Services Task Force are not required to be covered immediately after the release of the recommendation or guideline. Timing rules apply by law.
- B. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- C. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- D. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

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

Professional Services – The specific services rendered by an occupational therapist, physical therapist, speech pathologist or audiologist, Physician, or chiropractor for Covered Services provided.

Program – The Office of Group Benefits Program or Plan.

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

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

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

- A. Preferred 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.
- B. Participating Provider – A Provider that has a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan for other than a Preferred Network Provider.
- C. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan.

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 – The coordinated use of medical, social, educational or vocational services, beyond the stage of disease or injury, for the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

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.

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 retirement benefits 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:
 - a. Began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65; or

- b. Began employment after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or
 - c. Was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
 - d. Maintained continuous coverage with the Plan as an eligible Dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan.
- C. Immediately received retirement benefits 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/her 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 1, 2, or 3 above.

Significant Break in Coverage – A period of sixty-three (63) or more consecutive days during all of which an individual does not have any Creditable Coverage. Periods without coverage during an Eligibility Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

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 that provides:

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

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

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

Specialty Drugs – Biotechnology drugs or other drug products that may require special ordering, handling, and/or customer service, examples of which include, but are not limited to protein drugs, monoclonal antibodies, interferons, antisense drugs, epidermal growth factor inhibitors, and gene therapies.

Speech/Language Pathology Therapy – The treatment of a speech/language impairment or a swallowing impairment to improve or restore speech language deficits or swallowing deficits.

Stop Loss Provision - Represents the co-insurance amount for which the Plan Member is responsible. This amount does not include any deductibles or ineligible expenses. The Plan Member's Stop Loss will be the difference between the Plan's payment and the Eligible Expense.

Subrogation - The Plan's right to pursue the Covered Person's claims for medical or dental charges against a liability insurer, a responsible party, or the Covered Person.

Surgery

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

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 Claims Administrator's network if a Plan Participant requires non-emergency medical care or a Plan Participant requires Urgent Care after normal business hours of a Plan Participant's Physician.

Urgent Care Center – A clinic with extended 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 health care services, procedures and facilities.

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

Waiting Period – See Eligibility Waiting Period.

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

ARTICLE III.

SCHEDULE OF ELIGIBILITY

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

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

A. Persons to be Covered

1. Employee

- a. A full-time Employee as defined by a Participant Employer and in accordance with state law
- b. Husband and Wife, Both Employees - NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE. If a covered spouse chooses to be covered separately at a later date and is eligible for coverage as an Employee, 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

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

- (1) If employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if hired on July 1st, coverage will begin on August 1st).
 - (2) If employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15th, coverage will begin on September 1st).
 - (3) Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If completed after thirty (30) days following the date of employment, the Employee will be considered an Overdue Applicant.
 - (4) An Employee who transfers employment to another Participating Employer must complete a transfer form within thirty (30) days following the date of transfer to maintain coverage without interruption. If completed after thirty (30) days following the date of transfer, the Employee will be considered an Overdue Applicant and may be subject to pre-existing limitations. Overdue Applicants age nineteen (19) and older may be subject to the Pre-Existing Exclusion Period.
- d. Re-Enrollment, Previous Employment for Health Benefits
 - (1) An Employee, whose employment terminated while covered and is re-employed within twelve (12) months of the termination date, will be considered a Re-Enrollment Previous Employment applicant. A Re-Enrollment Previous Employment applicant will only be eligible for the classification of coverage (Employee, Employee and child(ren), Employee and spouse, Family) in force on the effective termination date.

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

e. Plan Participants of Boards and Commissions

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

f. Legislative Assistants

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

g. Pre-Existing Condition (PEC) – New Employees

- (1) The terms of the following paragraph apply to all eligible Employees and their Dependents whose employment with a Participating Employer begins on or after July 1, 2001.
- (2) The Plan Administrator may require that such applicants complete a “Statement of Physical Condition” form and an “Acknowledgment of Pre-Existing Condition” form.
- (3) Medical expenses incurred during the first twelve (12) months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately prior to the enrollment date of coverage. The provisions of this section do not apply to pregnancy or to Dependents under the age nineteen (19).
- (4) If the Covered Person was previously covered under a Group Health Plan, Medicare, Medicaid, or other creditable coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred without a break for sixty- three (63) days or more for the duration of prior coverage against the initial twelve (12)-month period. Any coverage occurring prior to a break in coverage, sixty-three (63) days or more will not be credited against a Pre-Existing condition exclusion period.

2. Retiree Coverage - Eligibility

- a. Retirees of Participant Employers are eligible for Retiree coverage under this Plan.
- b. An Employee retired from a Participant Employer may not be covered as an Employee.
- c. Retirees are not eligible for coverage as Overdue Applicants.
- d. 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 example, if retired July 15th, coverage will begin August 1st).

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 the covered Employee or covered Retiree acquires a Dependent. No Pre-Existing Condition Exclusion Period shall apply to Dependents under the age of nineteen (19).

b. Effective Dates of Coverage

(1) Documented Dependents of Employee -Coverage will be effective on the date the Employee becomes eligible for Dependent coverage.

(2) Documented Dependents of Retirees -Coverage for Dependents of Retirees will be effective on the first day of the month following the date of retirement if the Employee 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 of marriage for new spouses, the date of birth for newborn children, or the date acquired for other classifications of Dependents. Application must be made within thirty (30) days of the date of eligibility for coverage.

4. Pre-Existing Condition – Overdue Application

a. The terms of the following paragraphs apply to all eligible Employees who apply for coverage after thirty (30) days from the date the Employee became eligible for coverage and to all eligible Dependents of Employees and Retirees for whom the application for coverage was not completed within thirty (30) days from the date acquired. The effective date of coverage will be:

(1) The first day of the month following the date the Plan Administrator receives all required forms prior to the fifteenth (15th) of the month.

(2) The first day of the second month following the date the Plan Administrator receives all required forms on or after the fifteenth (15th) of the month.

b. The Plan Administrator will require that all Overdue Applicants complete a "Statement of Physical Condition" form and an "Acknowledgement of Pre-Existing Condition" form.

c. Medical expenses incurred during the first twelve (12) months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) month period immediately prior to the enrollment date of coverage. The provisions of this section do not apply to pregnancy or to Dependents under the age of nineteen (19).

d. If the Covered Person was previously covered under a group health plan, Medicare, Medicaid or other creditable coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred continuously for sixty-three (63) days or more for the duration of prior coverage against the initial twelve (12)-month period. Any coverage occurring prior to a break in coverage sixty-

three (63) days or more will not be credited against a Pre- Existing Condition exclusion period.

5. Special Enrollments – HIPAA

In accordance with HIPAA, certain eligible persons for whom the option to enroll for coverage was previously declined, and who would be considered Overdue Applicants, may enroll by written application to the Participant Employer under the following circumstances, terms, and conditions for special enrollments.

- a. Loss of Other Coverage - Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined because the Employees or Dependents had other coverage which terminated due to:
 - (1) Loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the Plan Participant; or
 - (2) Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer's contributions were ceased for cause or for failure of the individual participant to make contributions; or
 - (3) The Employee or Dependent having had COBRA continuation coverage under a Group Health Plan and the COBRA continuation coverage has been exhausted, as provided in HIPAA; or
 - (4) Effective April 1, 2009: Loss of eligibility due to termination of Medicaid or State Children's Health Insurance (SCHIP) coverage; or
 - (5) Effective April 1, 2009: Eligibility for premium assistance subsidy under Medicaid or SCHIP.
- b. After-Acquired Dependents - Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined when the Employee acquires a new Dependent by marriage, birth, adoption, or placement for adoption.
 - (1) A special enrollment application must be made within thirty (30) days of either the termination date of the prior coverage or the date the new Dependent is acquired, or within sixty (60) days as identified in #4 and #5 above. If the special enrollment application is made more than thirty (30) days, after eligibility or within sixty (60) days as identified in #4 and #5 above, they will be considered Overdue Applicants subject to a Pre-Existing Condition limitation. No Pre-Existing Condition Exclusion Period shall apply to Eligible Persons under the age of nineteen (19).
 - (2) The Effective Date of coverage shall be:
 - (i) For loss of other coverage or marriage, the first day of the month following the date the Plan Administrator receives all required forms for enrollment.
 - (ii) For birth of a Dependent, the date of birth.
 - (iii) For adoption, the date of adoption or placement for adoption.
 - (3) Special enrollment applicants must complete the "Acknowledgment of Pre-Existing Condition" form and "Statement of Physical Condition" forms.

- (4) Medical expenses incurred during the first twelve (12) months that coverage for the Special Enrollee is in force under this Plan will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the enrollment date. The provisions of this section do not apply to pregnancy or to Dependents under the age of nineteen (19).
- (5) If the Special Enrollee was previously covered under a Group Health Plan, Medicare, Medicaid or other creditable coverage as defined in HIPAA, the duration of the prior coverage will be credited against the initial twelve (12) month period used by the Plan Administrator to exclude benefits for a pre-existing condition if the termination under the prior coverage occurred within sixty-three (63) days of the date of coverage under the Plan.

6. Retirees Special Enrollment

Retirees will not be eligible for special enrollment, except under the following conditions:

- a. Retirement began on or after July 1, 1997.
- b. The Retiree can document that creditable coverage was in force at the time of the election not to participate or continue participation in the Plan.
- c. The Retiree can demonstrate that creditable coverage was maintained continuously from the time of the election until the time of requesting special enrollment.
- d. The Retiree has exhausted all COBRA and/or other continuation rights and has made a formal request to enroll within thirty (30) days of the loss of other coverage; and
- e. The Retiree has lost eligibility to maintain other coverage through no fault of his own and has no other creditable coverage in effect.

7. Health Maintenance Organization (HMO) Option

- a. In lieu of participating in the Plan, Employees and Retirees may elect coverage under an approved HMO.
- b. New Employees may elect to participate in an HMO during their initial period of eligibility. Each HMO will hold an annual enrollment period for coverage effective date of July 1. Transfer of coverage from the Plan to the HMO or vice-versa will only be allowed during this annual enrollment period.
 - (1) Transfer of coverage will be allowed as a result of the Employee being transferred into or out of the HMO geographic service area, with an effective date of the first day of the month following transfer.
- c. If a Covered Person has elected to transfer coverage but is hospitalized on July 1, the Plan providing coverage prior to July 1 will continue to provide coverage up to the date of discharge from the hospital.

8. Medicare Advantage Option for Retirees other than OGB sponsored plans (Effective July 1, 1999)

Retirees who are eligible to participate in a Medicare Advantage plan who cancel coverage with the Plan upon enrollment in a Medicare Advantage plan may re-enroll in the Plan upon withdrawal from or termination of coverage in the Medicare Advantage plan, at the earlier of the following:

- a. during the month of November, for coverage effective January 1st; or
- b. during the next annual enrollment, for coverage effective at the beginning of the next Plan Year.

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

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

An Employee granted leave of absence without pay for reasons other than those stated in Paragraph I, may continue to participate in an Office of Group Benefits benefit plan for a period up to twelve (12) months upon the Employee's payment of the full premiums due.

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

2. Disability

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 legal 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 attainment of the termination age for children, whichever occurs first.
 - (3) Surviving dependents will be entitled to receive the same Participant Employer premium contributions as Employees 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 for the Uniform Services (CHAMPUS/TRICARE) or successor will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a dependent child.
- b. A surviving spouse or Dependent cannot add new Dependents to continued coverage other than a child of the deceased Employee born after the Employee's death.
 - c. Participant Employer/Dependent Responsibilities
 - (1) It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Plan Administrator within sixty (60) days of the death of the Employee 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:
 - (i) Failure to pay the applicable premium timely.
 - (ii) Eligibility of the surviving spouse under a Group Health Plan other than Medicare.
 - (5) Coverage for a surviving dependent child under this section will continue until the earliest of the following events:
 - (i) Failure to pay the applicable premium timely.
 - (ii) Eligibility of the surviving dependent child for coverage under any Group Health Plan other than Medicare; or
 - (iii) The attainment of the termination age for children.
 - d. The provisions of paragraphs A through C this subsection 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.

4. Over-Age Dependents

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

- a. Prior to the Dependent Child reaching age twenty-six (26), an application for continued coverage with current medical information from the Dependent Child's attending Physician must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.
- b. Upon receipt of the application for continued coverage the Plan Administrator may require additional medical documentation regarding the Dependent Child's mental retardation or physical incapacity as often as it may deem necessary thereafter.

5. Military Leave

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

- a. Health Plan Participation - When called to active military duty, Participating Employees and covered Dependents may:
 - (1) continue participation in the health plan during the period of active military service, in which case the Participant Employer may continue to pay its portion of premiums; or
 - (2) cancel participation in the health plan during the period of active military service, in which case such plan participants may apply for reinstatement of OGB coverage within thirty (30) days of:
 - (i) the date of the EMPLOYEE'S re-employment with a participating employer;
 - (ii) the Dependent's date of discharge from active military duty; or
 - (iii) the date of termination of extended health coverage provide as a benefit of active military duty, such as TRICARE Reserve Select. Plan participants who elect this option and timely apply for reinstatement of OGB coverage will not be subject to a pre-existing condition (PEC) limitation, and the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding rules promulgated by OGB.

C. COBRA

1. Employees

- a. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of

Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

- b. It is the responsibility of the Participant Employer to notify the Plan Administrator within thirty (30) days of the date coverage would have terminated because of any of the foregoing events and the Plan Administrator will notify the Employee within fourteen (14) days of his right to continue coverage.
- c. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification, and premium payment must be made within forty-five (45) days of the date the Employee elects continued coverage, for coverage 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, but only after any pre-existing condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or
 - (5) The Employer ceases to provide any group health plan for its Employees.
- e. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered spouse and/or covered dependent children may elect to continue coverage at his own expense. The elected coverage will be subject to the above stated notification and termination provisions.

2. Surviving Dependents

- a. Coverage under this Plan for covered surviving Dependents of an Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.
- b. It is the responsibility of the Participant Employer or surviving covered Dependents to notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree. The Plan Administrator will notify the surviving dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification.
- c. Premium payment must be made within forty-five (45) days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for the surviving Dependents under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premium timely.
 - (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated.

- (3) Entitlement to Medicare.
- (4) Coverage under a Group Health Plan, but only after Pre-Existing Condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or
- (5) The Employer ceases to provide any Group Health Plan for its Employees.

3. Divorced Spouse

- a. Coverage under this Plan for an Employee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the Employee or Retiree, unless the covered divorced spouse elects to continue coverage at his own expense.
- b. It is the responsibility of the divorced spouse to notify the Plan Administrator within sixty (60) days from the date of divorce, and the Plan Administrator will notify the divorced spouse within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the election notification.
- c. Premium payment must be made within forty-five (45) days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for the divorced spouse under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premium timely.
 - (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group Health Plan, but only after any Pre-Existing Condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or
 - (5) The Employer ceases to provide any group health plan for its Employees.

4. Dependent Children

- a. Coverage under this plan for a covered dependent child of a covered Employee or Retiree 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 elects to continue coverage at his own expense.
- b. It is the responsibility of the Dependent to notify the Plan Administrator within sixty (60) days of the date coverage would have terminated and the Plan Administrator will notify the Dependent within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of the election notification.

- c. Premium payment must be made within forty-five (45) days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for children 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, but only after any Pre-Existing Condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or
 - (5) The Employer ceases to provide any group health plan for its Employees.

5. Dependents of COBRA Participants

- a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered spouse or a covered dependent child becomes ineligible for coverage due to:
 - (1) Death of the Employee.
 - (2) Divorce from the Employee; or
 - (3) A dependent child no longer meets the definition of an eligible covered Dependent.

Then, the spouse and/or dependent child may elect to continue COBRA coverage at his own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

- b. It is the responsibility of the spouse and/or the dependent child to notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.
- c. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- d. Coverage for the children 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, but only after any pre-existing condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or

(5) The Employer ceases to provide any group health plan for its Employees.

6. Disability COBRA

- a. If a covered Employee or covered Dependent is determined by the Social Security Administration or by the Plan Administrator staff (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient "quarters" of employment) to have been totally disabled on the date the Covered Person became eligible for continued coverage or within the initial eighteen (18) months of coverage, coverage under this Plan for the Covered Person who is totally disabled 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, the Covered Person must:
 - (1) Submit a copy of his Social Security Administration's disability determination to the Plan Administrator before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:
 - (i) The date of issuance of the Social Security Administration's disability determination; and
 - (ii) The date on which the qualified beneficiary loses (or would lose) coverage under terms of the Plan as a result of the covered Employee's termination or reduction of hours.
 - (2) In the case of a person who is ineligible for Social Security disability benefits due to insufficient *quarters* of employment, submit proof of total disability to the Plan Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the Plan 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 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 COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.
- e. Coverage under this section will continue until the earliest of the following:
 - (1) Failure to pay the applicable premium timely.
 - (2) Twenty-nine (29) months from the date coverage would have otherwise terminated.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group Health Plan, but only after any Pre-Existing Condition exclusions of that other plan for a Pre-Existing Condition of the Covered Person has been exhausted or satisfied.

- (5) The Employer ceases to provide any group health plan for its Employees; or
- (6) Thirty (30) days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Plan Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient *quarters* of an employment, thirty (30) days after the month in which the Plan Administrator determines that the Covered Person is no longer disabled.

7. Medicare COBRA

- a. If an Employee becomes entitled to Medicare less than eighteen (18) months before the date the Employee's eligibility for benefits under this Plan terminates, the period of continued coverage available for the Employee's covered Dependents will continue until the earliest of the following:
 - (1) Failure to pay the applicable premium timely.
 - (2) Thirty-six (36) months from the date of the Employee's Medicare entitlement.
 - (3) Entitlement to Medicare.
 - (4) Coverage under a Group Health Plan, but only after any pre-existing conditions exclusions of that other plan for a Pre-Existing Condition of the Covered Person have been exhausted or satisfied; or
 - (5) The Employer ceases to provide any group health plan for its Employees.
- b. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

8. Miscellaneous Provisions

During the period of continuation, benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Employees and Retirees.

9. Special Second Election Period for Certain Trade-Displaced Individuals who did not Elect COBRA Coverage

Special COBRA rights apply to employees who lost health coverage as a result of a termination or reduction of hours and who qualify for a "trade adjustment allowance (TAA)" or "alternative trade adjustment assistance (ATAA)" under a federal law called the Trade Act of 2002 and as amended by ARRA. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. The sixty (60) day period beginning on the first day of the month in which an eligible employee becomes a TAA or ATAA eligible individual, but only if the election is made within six (6) months immediately after the eligible employee's Group health plan coverage ended. If the Plan Participant qualifies or may qualify for assistance under the Trade Act of 2002, and as amended by ARRA, the Plan Participant should contact the Group's Human Resources Manager for additional information. **THE MEMBER MUST CONTACT THE GROUP'S HUMAN RESOURCES MANAGER PROMPTLY AFTER QUALIFYING FOR ASSISTANCE UNDER THE TRADE ACT OF 2002, AND AS AMENDED BY ARRA, OR THE MEMBER WILL LOSE HIS SPECIAL COBRA RIGHTS.**

D. Change of Classification

1. Adding or Deleting Dependents

The Plan Participant must notify the Plan Administrator when a Dependent is added to or deleted from the Plan Participant's coverage that results in a change in the class of coverage. Notice must be provided within thirty (30) days of the addition or deletion.

2. Change in Coverage

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

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

3. Notification of Change

It is the Employee's responsibility to notify the Plan Administrator of any change in classification of coverage that affects the Employee's contribution amount. If failure to notify is later determined, it will be corrected on the first day of the following month.

E. Contributions

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

F. Medical Child Support Orders

An individual who is a child of a covered Employee shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

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

1. Provides for support of a covered Employee's child.
2. Provides for health care coverage for that child.
3. Is made under state domestic relations law (including a community property law).
4. Relates to Benefits under the Plan; and (e) is "qualified" in that it meets the technical requirements of applicable state law.

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

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the dependent child of a non-custodial parent who is (or will become) a Covered Person by a domestic relations order that provides for health care coverage. Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the Plan Administrator.

ARTICLE IV.

BENEFITS

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

A. Payments

1. Subject to the Deductible Amount shown in the Schedule of Benefits, the maximum limitations hereinafter provided and other terms and provisions of this Benefit Plan, the Group will provide Benefits in accordance with the percentage shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period.
 - a. For Plan Participants in a class of coverage with more than one Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Benefit Period Deductible Amount. However, no family Plan Participant may contribute more than the Benefit Period Deductible Amount to satisfy the maximum amount required of a family.
 - b. The Plan does not provide a fourth-quarter Deductible carryover for charges incurred for Covered Services incurred during the months of October, November and December.
 - c. The Plan will apply the Plan Participant's Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by the Claims Administrator. The Claims Administrator's system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays his Deductible Amount, he is entitled to receive a refund from the Provider in which the overpayment was made.
2. Except as stated below, when a Plan Participant meets the Out-of-Pocket Amount shown in the Schedule of Benefits, the Plan will provide Benefits equal to one hundred percent (100%) of the Allowable Charge for Covered Services during the remainder of the Benefit Period.
3. Under certain circumstances, if the Plan pays the healthcare provider amounts that are the Plan Participant's responsibility, such as Deductibles, Copayments or Coinsurance, the Plan may collect such amounts directly from You. You agree that the Plan has the right to collect such amounts from You.

B. Out-of-Pocket Amount

1. After the Plan Participant has met the Out-of-Pocket Amount, as shown in the Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Plan Participant's Coinsurance amount which is based on the Allowable Charge.
2. The following do apply toward satisfying the Out-of-Pocket Amount of this Benefit Plan:
 - a. Coinsurance
 - b. Deductible Amounts

3. The following do not apply toward satisfying the Out-of-Pocket Amount of this Benefit Plan:
 - a. any charges in excess of the Allowable Charge;
 - b. any penalties the Plan Participant or Provider must pay;
 - c. charges for non-covered services; and
 - d. any amounts paid by the Plan Participant other than Coinsurance.

C. Accumulator Transfers

Plan Participants' needs sometimes require that they transfer from one policy or plan to another. Types of transfers include, but are not limited to moving from one employer's plan to another, from a group policy or plan to an individual policy, an individual policy to a group policy or plan, or a policy with one insurance company to a policy with another insurance company.

The type of transfer being made determines whether the Plan Participant's accumulators are carried from the old policy or plan to the new policy or plan. Accumulators include, but are not limited to, Deductibles, Out-of-Pocket Amounts, or Benefit Period Maximums.

ARTICLE V. HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-emergency, Emergency, Pregnancy Care, Mental Health and substance abuse Admissions) must be Authorized as outlined in the Care Management Article of this Benefit Plan. In addition, at regular intervals during the Inpatient stay, the Claims Administrator will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care. The Plan Participant must pay any Deductible Amount, Copayment, and any Coinsurance percentages shown in the Schedule of Benefits. The following services furnished to a Plan Participant by a Hospital are covered:

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Plan Participant requiring an intensive level of care.
3. In a hospital-based Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital. 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 Mental Health or substance abuse Benefits.

B. 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. All charges are subject to the applicable deductibles, copayments, and/or coinsurance amounts as shown in the Schedule of Benefits.

1. Hospital Care includes the medical services, supplies, treatment, drugs, and devices furnished by a hospital or ambulatory surgical center. Benefits are available as shown in the Schedule of Benefits;
2. Use of operating, delivery, recovery and treatment rooms and equipment.
3. Covered Services of a Physician;
4. Routine Nursing Services, i.e., "floor nursing" services provided by nurses employed by the hospital are considered as part of the room and board;
5. Anesthesia and its administration when ordered by the operating Physician and administered by an appropriately licensed nurse anesthetist or Physician in conjunction with a covered surgical service;
6. Laboratory examinations and diagnostic 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, as well as the following surgical and medical supplies furnished by covered Providers:
 - a. Catheters - External and Internal
 - b. Cervical Collar
 - c. Leg Bags for Urinal Drainage
 - d. Ostomy Supplies, except supplies for nutritional and/or enteral feeding
 - e. Prosthetic Socks
 - f. Prosthetic Sheath
 - g. Sling (Arm or Wrist)
 - h. Suction Catheter for Oral Evacuation
 - i. Surgical Shoe (following foot surgery only)
 - j. Plaster Casts
 - k. Splints
 - l. Surgical Trays (for certain procedures)
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.

C. Emergency Room

The Plan Participant may have to pay applicable Deductible Amounts as shown in the Schedule of Benefits, for each visit to an Emergency room for treatment. The Emergency room Deductible is waived if an Emergency visit results in an Inpatient Admission. 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 In-Network level.

D. Pre-Admission Testing Benefits

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

ARTICLE VI.

MEDICAL AND SURGICAL BENEFITS

Benefits for the following surgical and medical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. A Plan Participant must pay any applicable Deductible Amounts, Copayments 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 Plan and is that period of time which is appropriate as routine care for the particular surgical procedure.
- b. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

2. Multiple Surgical Procedures - When Medically Necessary multiple procedures (concurrent, successive, or other multiple surgical procedures) are performed at the same surgical setting, Benefits 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.

5. Second Surgical Opinion

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

B. Inpatient Medical Services

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

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

C. Outpatient Medical Services and Surgical Services

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

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

Blue Cross and Blue Shield of Louisiana provides claims payment services ONLY for those Prescription Drugs administered during an Inpatient or Outpatient stay and those medically necessary/non-investigational drugs requiring parenteral administration in a physician's office. Additionally, drugs that can be self-administered that are provided to a Plan Participant in a physician's office are payable under this medical Benefit.

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 Administrator. See the Schedule of Benefits for more information.

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

The following services are available to members. Coinsurance is payable when indicated on the chart below, at the percentage shown on the Schedule of Benefits.

WHAT A MEMBER PAYS FOR PREVENTIVE OR WELLNESS CARE BENEFITS

EXAMINATIONS AND TESTING BENEFITS:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
<p>Routine Wellness Physical Examination – Certain routine wellness diagnostic tests ordered by Your Physician are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels.</p> <p>NOTE: Higher tech services such as an MRI, MRA, CT scan, PET scan, nuclear cardiology, and endoscopy are not covered under this Preventive or Wellness Benefit. These higher tech services may be covered under standard contract Benefits when the tests are Medically Necessary.</p>	No Cost	Coinsurance
Well Baby Care	No Cost	Coinsurance
<p>Prostate Cancer Screening – One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age.</p> <p>A second visit shall be permitted for follow-up treatment within sixty (60) days after the visit if related to a condition diagnosed or treated during the visit and recommended by a Physician.</p>	No Cost	Coinsurance

Colorectal Cancer Screening –		
<ul style="list-style-type: none"> • Fecal occult blood test: One (1) annually for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. 	No Cost	Coinsurance
<ul style="list-style-type: none"> • Flexible sigmoidoscopy: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. 	No Cost	Coinsurance
<ul style="list-style-type: none"> • Colonoscopy: One (1) every ten (10) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. 	No Cost	Coinsurance
<ul style="list-style-type: none"> • Other screening procedures as most recently recommended by the United States Preventive Services Task Force (USPSTF) and the American College of Gastroenterology, in consultation with the American Cancer Society. Services we deem Investigational are not covered. 	No Cost	Coinsurance
IMMUNIZATIONS:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
All state mandated immunizations including the complete basic immunization series as defined by the state health officer and required for school entry for children up to age six (6).	No Cost	Coinsurance
Immunizations recommended by the Member's Physician.	No Cost	Coinsurance
Seasonal Flu and H1N1 Immunizations	No Cost	Coinsurance
SCREENINGS AND COUNSELING:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Abdominal Aortic Aneurysm Screening: One per Benefit Period for Men ages 65-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Coinsurance
Alcohol Misuse Screening and Counseling	No Cost	Coinsurance
Aspirin Counseling	No Cost	Coinsurance
Blood Pressure Screening	No Cost	Coinsurance
Cholesterol Screening	No Cost	Coinsurance
Depression Screening	No Cost	Coinsurance
Type 2 Diabetes Screening	No Cost	Coinsurance
Diet Counseling	No Cost	Coinsurance
HIV Screening	No Cost	Coinsurance
Obesity Screening and Counseling	No Cost	Coinsurance
Sexually Transmitted Infection Counseling	No Cost	Coinsurance

Tobacco Use Screening	No Cost	Coinsurance
Syphilis Screening	No Cost	Coinsurance
COVERED SERVICES FOR WOMEN:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Counseling for - BRCA genetic testing and breast cancer chemoprevention.	No Cost	Coinsurance
Routine Gynecologist / Obstetrician Visits. Additional visits recommended by the Member's Gynecologist / Obstetrician may be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Coinsurance
Routine Wellness Physical Examination	No Cost	Coinsurance
Mammography Examination - One (1) every twelve (12) months. Additional mammography examinations recommended by the Member's Physician may be subject to Copayments, Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Coinsurance
Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; additional screenings will be subject to Deductible Amounts and Coinsurance percentages as shown in the Schedule of Benefits. (Bone Mass Measurement Benefits are located in the "Other Covered Services, Supplies or Equipment" section of this Benefit Plan)	No Cost	Coinsurance
Routine Pap Smear - One (1) per Benefit Period	No Cost	Coinsurance
Screenings – Chlamydia Infection and Gonorrhea	No Cost	Coinsurance
Screening for HIV	No Cost	Coinsurance
Counseling for HIV	No Cost	Coinsurance
Sexually Transmitted Disease Screening	No Cost	Coinsurance
Sexually Transmitted Disease Counseling	No Cost	Coinsurance
HPV DNA testing for ≥ 30 years old – limitation of 1 per 3 years initially with all remaining processing per contract benefits.	No Cost	Coinsurance
Generic Folic Acid Supplements for Women 18-45 years of age – 0.4mg to 0.8mg/day (Pharmacy Benefit)	No Cost	Members who fill prescriptions at an out of network pharmacy must pay cash at the point of sale and file a paper claim for reimbursement. For covered medications, members are responsible for paying their applicable cost share plus any amount that is charged in excess of the plan allowable.
Barrier Contraceptive Method – Diaphragm	No Cost	
Generic Hormonal Contraceptive Method – Oral (Pharmacy Benefit)	No Cost	
Generic Emergency Contraceptive Method – Oral Morning After Pill, requires prescription for all ages for Benefit (Pharmacy Benefit)	No Cost	
Brand Hormonal Contraceptive Method – Oral (Pharmacy Benefit)	Contract Benefits	
Brand Emergency Contraceptive Method – Oral Morning After Pill, requires prescription for all ages for benefit (Pharmacy Benefit)	Contract Benefits	
Implantable Contraceptive Method – IUD (Complications resulting from this procedure are subject to Deductible and Coinsurance)	No Cost	Coinsurance

Breast Feeding Intervention	No Cost	Coinsurance
Lactation Counseling	No Cost	Coinsurance
Lactation Supplies for Machine Use Only	No Cost	Coinsurance
Manual pump	No Cost	Coinsurance
Counseling for Violence and Domestic Abuse	No Cost	Coinsurance
COVERED SERVICES FOR WOMEN WITH PREGNANCY CARE COVERAGE:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Sterilization Method - Tubal Ligation - Facility with Delivery	Maternity Benefit	Maternity Benefit
Sterilization Method - Tubal Ligation - Facility without Delivery	No Cost	Coinsurance
Sterilization Method - Tubal Ligation - Professional with Delivery	No Cost	Coinsurance
Sterilization Method - Tubal Ligation - Professional without Delivery	No Cost	Coinsurance
Sterilization Method - Tubal Ligation - Anesthesia	No Cost	No Cost
COVERED SERVICES FOR WOMEN WITHOUT PREGNANCY CARE COVERAGE:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Sterilization Method - Tubal Ligation - Facility with Delivery	No Coverage	No Coverage
Sterilization Method - Tubal Ligation - Facility without Delivery	No Cost	Coinsurance
Sterilization Method - Tubal Ligation - Professional with Delivery	No Cost	Coinsurance
Sterilization Method - Tubal Ligation - Professional without Delivery	No Cost	Coinsurance
Sterilization Method - Tubal Ligation - Anesthesia	No Cost	No Cost
<i>NOTE: Complications resulting from a Tubal Ligation are subject to Deductible and Coinsurance.</i>		
COVERED SERVICES FOR PREGNANT WOMEN WITH PREGNANCY CARE COVERAGE:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Anemia Screening	No Cost	Coinsurance
Bacteriuria Screening	No Cost	Coinsurance
Hepatitis B Screening	No Cost	Coinsurance
Rh Incompatibility Screening	No Cost	Coinsurance
Gestational Diabetes Testing and Screening	No Cost	Coinsurance
COVERED SERVICES FOR PREGNANT WOMEN WITHOUT PREGNANCY CARE COVERAGE:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Anemia Screening	No Cost	No Coverage
Bacteriuria Screening	No Cost	No Coverage
Hepatitis B Screening	No Cost	No Coverage
Rh Incompatibility Screening	No Cost	No Coverage
Gestational Diabetes Testing and Screening	No Cost	No Coverage
COVERED SERVICES FOR CHILDREN:	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Alcohol and Drug Use Assessments	No Cost	Coinsurance
Autism Screening: Ages 1-2	No Cost	Coinsurance
Behavioral Assessments	No Cost	Coinsurance
Cervical Dysplasia Screening	No Cost	Coinsurance
Congenital Hypothyroidism Screening	No Cost	Coinsurance
Developmental Screening: Ages 0-3	No Cost	Coinsurance
Dyslipidemia Screening	No Cost	Coinsurance
Hearing Screening: One per Benefit Period for Children Ages 0-21; additional screenings will be subject to Deductible Amounts and Coinsurance percentages as shown in the Schedule of Benefits.	No Cost	Coinsurance

Height, Weight and Body Mass Index Measurements	No Cost	Coinsurance
Hematocrit or Hemoglobin Screening	No Cost	Coinsurance
Sickle Cell Screening: Newborns	No Cost	Coinsurance
HIV Screening	No Cost	Coinsurance
Lead Screening: One per Benefit Period for Ages 0-6; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Coinsurance
Obesity Screening and Counseling	No Cost	Coinsurance
Oral Health Assessment	No Cost	Coinsurance
Phenylketonuria (PKU): Newborns	No Cost	Coinsurance
Sexually Transmitted Infection Counseling	No Cost	Coinsurance
Tuberculosis Screening: One per Benefit Period for Ages 0-21; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Coinsurance
Vision Screening: One per Benefit Period for Ages 0-21; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	No Cost	Coinsurance

ARTICLE IX. MENTAL HEALTH BENEFITS

BENEFITS FOR SERVICES RENDERED BY A NON-PSYCHIATRIC PROVIDER FOR A MENTAL HEALTH OR SUBSTANCE ABUSE DISORDER ARE LIMITED TO ONE MEDICAL VISIT PER PLAN YEAR, AND ARE SUBJECT TO THE DEDUCTIBLE AND COINSURANCE.

- A. Treatment of Mental Disorders is covered subject to any limitations shown in the Schedule of Benefits. Treatment must be rendered by a Psychiatrist or an Allied Health Professional licensed to perform Mental Health Services. 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. Mental Health services (Medical Visit Only) rendered by a Non-Psychiatric Provider are limited to one visit per Plan Year, and are subject to the Deductible and Coinsurance shown on the Schedule of Benefits. Benefits are limited to one visit per Plan Year.

This limitation does not apply to the treatment of the following:

- 1. Attention Deficit Disorder
- 2. Autism
- 3. Attention Deficit Hyperactivity Disorder
- 4. Tourette's Syndrome
- 5. Bulimia

6. Anorexia
7. Applied Behavioral Analysis (ABA)

ARTICLE X. SUBSTANCE ABUSE BENEFITS

- A. Benefits for treatment of substance abuse are available only if shown as Covered Services in the Schedule of Benefits, and will be subject to any limitation shown. 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 Psychiatrist or an Allied Health Professional licensed to perform Substance Abuse services.
- B. Inpatient treatment for substance abuse must be Authorized as provided in the Care Management Article of this Benefit Plan, when coverage for substance abuse is provided.

ARTICLE XI. ORAL SURGERY BENEFITS

Coverage is provided only for the following services or procedures. The highest level of Benefits are available when services are performed by a 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, or call the Customer Service telephone number on the Your ID card for a copy of the directory.

- A. Oral and maxillofacial surgeries which are shown to the satisfaction of the Claims Administrator to be Medically Necessary, non-dental, non-cosmetic procedures. Excision of exostoses or tori of the jaws and hard palate, incision and drainage of abscess and treatment of Cellulitis, incision of accessory sinuses, salivary glands, and salivary ducts, anesthesia for these services or procedures when rendered by an oral surgeon or a dentist who holds all required permits or training to administer such anesthesia.
- B. Dental procedures necessitated as a result of or secondary to cancer, which are shown to the satisfaction of the Claims Administrator to be Medically Necessary. Benefits are available for dental services not otherwise covered by this Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To determine if the Plan Participant is eligible for these Benefits, please call the Claims Administrator's Customer Service Unit at the phone number on the Plan Participant's ID card, and ask to speak to a Case Manager.
- C. When excision of one or more impacted teeth is performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) while coverage is in force, the Claims Administrator will pay, without deductible, the Eligible Expense actually incurred for the surgical procedure.
- D. If a Covered Person requires dental treatment in a hospital setting that is otherwise an Eligible Expense, the Plan will provide benefits for anesthesia rendered in the hospital and associated hospital charges. Prior authorization for hospitalization for dental treatment is required in the same manner as prior authorization is required for other covered medical services.

Eligible Expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care, anesthesia, radiology, pathology services, and facility charges are subject to a deductible, coinsurance, and the maximum benefit provisions of the Plan.

- E. Dental Care and Treatment rendered by a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) including Surgery to correct Accidental Injuries of sound natural teeth. Benefits are available if:

1. Coverage was in effect with respect to the individual at the time of the accident;
 2. Treatment commences within 90 days from the date of the accident and is completed within two years from the date of the accident;
 3. Coverage remains continuously in effect with respect to the Covered Person during the course of the treatment;
 4. Eligible Expenses will be limited to the cost of treatment as estimated at the time of initial treatment;
 5. Eligible Expenses may include dental braces and orthodontic appliances, upon review and approval by the Claims Administrator, and only under the following circumstances:
 - a. To return the alveolar alignment to its former state prior to a covered dental accident. The Claims Administrator will allow benefits for orthopedic correction to establish reasonable occlusal function;
 - b. A covered surgery that requires the use of braces for stabilization;
 - c. Severe skeletal deformity (i.e., cleft palate). The Claims Administrator will allow benefits for orthopedic correction to establish reasonable occlusal function.
 6. As used herein, Accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force;
- F. Splint therapy for the treatment of Temporomandibular Joint dysfunction (TMJ) repair; limited to a maximum six-hundred (\$600.00) dollar Lifetime Benefit for a splint and initial panorex x-ray only. Surgical treatment for TMJ will only be eligible following a demonstrated failure of splint therapy and upon approval by the Claims Administrator.

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

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

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

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) **for the specific** organ or transplant or a Blue Cross and Blue Shield of Louisiana (BCBSLA) Preferred Network Provider facility, unless otherwise approved by the Claims Administrator in writing. To locate a BDCT or BCBSLA Preferred Network Provider facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their ID card.
2. The transplantation must not be considered experimental or investigational.
3. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).
4. Benefits associated with an organ transplant procedure include expenses for patient screening, organ procurement, transportation of the organ, transportation of the patient and/or donor, surgery for the patient and donor. The Plan will not cover expenses for the transportation of surgeons or family members of either the patient or donor.

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

C. Solid Human Organ Transplants

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

D. Tissue Transplant Procedures (Autologous and Allogeneic)

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

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

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

ARTICLE XIII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

Pregnancy Care as described in this Article of the Benefit Plan is covered only if shown as covered in the Schedule of Benefits. If Pregnancy Care is not covered, complications of pregnancy are not covered, except for ectopic pregnancies and spontaneous abortions (miscarriages). Benefits for treatment of ectopic pregnancies and spontaneous abortions are available for all covered Plan Participants under Article V and VI of this Benefit Plan.

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

Plan Participants deliver healthy babies. Please call Our Customer Service Department at the number on the back of Your ID card when You learn You are having a baby. When You call, we'll let You know what s are available to You.

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

A. Pregnancy Care

1. Surgical and Medical Services.
 - a. Initial office visit and visits during the term of the pregnancy.
 - b. Diagnostic Services.
 - c. Delivery, including necessary pre-natal and post-natal care.
 - d. Midwifery services performed by a certified midwife or a certified nurse midwife.
 - e. 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.

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

1. Surgical and medical 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.
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 a well newborn, 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.

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 or issuer may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or Newborn earlier.

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

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

ARTICLE XIV. REHABILITATIVE CARE BENEFITS

Rehabilitative Care Benefits will be available for services provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, and/or Chiropractic Services. Benefits are available when the therapy is rendered by a Provider licensed and practicing within the scope of his license. The Plan Participant must be able to tolerate a minimum of three (3) hours of active 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.

A. Occupational Therapy

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

B. Physical Therapy

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license.
2. Physical Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.
3. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.
4. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances, if listed as a Covered Service:
 - a. To children with a diagnosed developmental disability pursuant to the Plan Participant's plan of care.
 - b. As part of a home health care agency pursuant to the Plan Participant's plan of care.
 - c. To a patient in a nursing home pursuant to the Plan Participant's plan of care.
 - d. Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention in adults age sixty-five (65) and older.
 - e. To an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the health care Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the health care Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

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

D. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.
2. Chiropractic Services are not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.
3. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for the rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

ARTICLE XV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. Acupuncture

Benefits are available for acupuncture when:

1. rendered by a licensed medical doctor,
2. medically necessary and appropriate and is provided within the scope of the acupuncturist's license; or
3. the acupuncture is performed in lieu of generally accepted anesthesia practices.

B. Ambulance Service Benefits

Professional ambulance services that are Medically Necessary, subject to the following provisions:

1. Licensed professional ambulance service in a vehicle licensed for highway use to or from a hospital with facilities to treat an illness or injury;

2. Licensed air ambulance service to a hospital with facilities to treat an illness or injury;

C. Attention Deficit/Hyperactivity Disorder

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

D. Autism Spectrum Disorders (ASD)

ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Plan Participants who have not yet reached their seventeenth (17th) birthday are eligible for Applied Behavior Analysis when the Claims Administrator determines it is Medically Necessary. Applied Behavior Analysis is not covered for Plan Participants age seventeen (17) and older.

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

E. Bone Mass Measurement

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

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

Deductible, Coinsurance and/or Copayment amounts are applicable. One (1) osteoporosis screening per Benefit Period is available to women age 60 and older, under the "Preventive or Wellness Care" Article of this Benefit Plan, at no cost to Members receiving care from a Network Provider.

F. Breast Reconstructive Surgery Services

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. reconstruction of the breast on which the mastectomy has been performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.
2. These Covered Services shall be delivered in a manner determined in consultation with the attending Physician and the Plan Participant and, if applicable, will be subject to any Deductible, Copayment and Coinsurance.

G. Cleft Lip and Cleft Palate Services

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

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

H. Clinical Trial Participation

1. This Plan shall provide coverage for patient costs incurred as a result of a treatment being provided in accordance with a clinical trial for cancer. Coverage will be subject to any applicable Copayment, Deductible, or Coinsurance amounts shown in the Schedule of Benefits.
2. The following services are not covered:
 - a. non-health care services provided as part of the clinical trial;
 - b. costs for managing research data associated with the clinical trial;
 - c. Investigational drugs or devices; and/or
 - d. services, treatment or supplies not otherwise covered under this Benefit Plan.
3. Investigational 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 for the prevention or early detection of cancer.
 - b. The treatment is being provided or the studies are being conducted in a Phase 1, II, Phase III, or Phase IV clinical trial for cancer.
 - c. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
 - (1) One of the United States National Institutes of Health.
 - (2) A cooperative group funded by one of the National Institutes of Health.
 - (3) The FDA in the form of an investigational new drug application.

- (4) The United States Department of Veterans Affairs.
 - (5) The United States Department of Defense.
 - (6) A federally funded general clinical research center.
 - (7) The Coalition of National Cancer Cooperative Groups.
- d. 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.
 - e. 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.
 - f. There must be no clearly superior, non-investigational approach.
 - g. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.
 - h. The patient has signed an institutional review board approved consent form.

J. Diabetes Education and Training for Self-Management

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

K. 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.

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered at the Coinsurance percentages 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 Plan's option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.
 - (3) Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Plan Participant selects deluxe equipment solely for his comfort or convenience.
 - (4) Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
 - (5) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.
 - (6) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. 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.
 - (7) Surgical pressure support hose, maximum three (3) pairs per plan year.
 - (8) Ortho-mammary surgical brassieres, maximum three (3) per plan year.
 - (9) Orthopedic shoes prescribed by a Physician and completely custom built, limited to one pair per Plan Year.
- 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) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by the Plan.

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

3. Prosthetic Appliances and Devices (Non-Limb)

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

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.
- b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Plan will determine this time period.
- c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience.
- d. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.

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

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

- a. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Plan will determine this time period.
- b. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience. A Plan Participant may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Plan and may pay the difference between the price of

the device and the benefit payable, without financial or contractual penalty to the Provider of the device.

- c. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.
- d. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

M. Hearing Aid Benefits

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 or licensed hearing aid specialist following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

The Plan will pay up to the Allowable Charge for this Benefit. The Plan may increase their Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge. In no event will the Plan pay more than one-thousand, four hundred (\$1,400.00) dollars per hearing aid, per ear, in a thirty-six (36) month period. If the Plan Participant purchases a hearing aid that costs more than one-thousand, four hundred (\$1,400.00), the Plan Participant will be responsible for all amounts above one-thousand, four hundred (\$1,400.00) dollars. Charges over one-thousand, four hundred (\$1,400.00) dollars are non-covered charges and do not accrue to the Plan Participant's Out-of-Pocket Amount. This Benefit is not subject to Coinsurance or Deductibles.

N. Hospice and Home Health Care Benefits

1. Hospice Care is covered and may be limited if 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, and may be limited if shown in the Schedule of Benefits.
3. Benefits are not available for Hospice and Home Health Care when Medicare is primary to this Plan.

P. Permanent Sterilization Procedures and Contraceptive Devices

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

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

Q. Prescription Drugs

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

R. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Only sleep studies performed in the home or sleep studies performed in a sleep

laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM) are eligible for coverage.

S. X-rays, Lab Tests, Machine Tests, and High Tech Imaging

Medically necessary X-rays, lab tests, machine tests, and high tech imaging, including but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology, are subject to Deductible and Coinsurance.

ARTICLE XVI.

CARE MANAGEMENT

A. Authorization of Admissions

1. Elective Admissions

- a. The Plan Participant is responsible for ensuring that his Provider contacts 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.
- b. If a request for Authorization is denied, the Admission is not covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission for which Authorization was denied.
- c. If Authorization is not requested prior to the services being rendered, in addition to any Deductible Amount and Coinsurance amount required in this Benefit Plan, the Plan Participant will be responsible for all charges for Hospital services not specifically listed as Covered Services during the Admission and for any penalty amount shown in the Schedule of Benefits. Additionally, all days not Authorized will be reviewed for Medical Necessity and could be denied.
- d. 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 will not apply toward satisfying the Out-of-Pocket Amount.

2. Emergency Admissions

- a. 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.

- b. If Authorization is denied, the Admission will not be covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission.
 - c. If Authorization is not requested, in addition to any Deductible Amount and Coinsurance amount required in this Benefit Plan, the Plan Participant will be responsible for all charges for Hospital services not specifically listed as Covered Services during the Admission and for the penalty amount shown in the Schedule of Benefits. Additionally, all days not Authorized will be reviewed for Medical Necessity and could be denied.
 - d. Additional amounts the Plan Participant is responsible for because Authorization of an Emergency Admission was denied or not requested will not apply toward the Out-of-Pocket Amount.
3. Concurrent Review
- a. 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.
 - b. 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.
 - c. 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.
 - d. Charges for non-authorized days in the Hospital that the Plan Participant must pay will not apply toward satisfying the Out-of-Pocket Amount.
4. Prior Authorization and Concurrent Review Authorization establish the Medical Necessity and duration of inpatient hospital confinement.
- a. It is the Provider's responsibility to obtain Prior Authorization for Network facilities. If the Provider fails to do this, the Plan Participant cannot be billed for any amount not covered by this Plan.
 - b. It is the Plan Participant's responsibility to obtain Prior Authorization and Concurrent Review Authorization for Non-Network facilities.

- c. If Prior Authorization is not obtained for Non-Network facilities, Benefits otherwise payable will be reduced by twenty-five percent (25%).

5. 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. It is the Provider's responsibility to obtain Prior Authorization for outpatient services at Network facilities. If Prior Authorization is not obtained by the Provider, the Plan Participant cannot be billed for any amount not covered by this Plan.
- b. It is the Plan Participant's responsibility to obtain Prior Authorization for outpatient services at Non-Network facilities. If Prior Authorization is not obtained for Non-Network facilities, no benefits are payable under this Plan.

6. Appeals

- a. If either the Plan Participant or the Provider disagrees with the denial of any Authorization, the denial may be appealed as shown in the Complaints, Grievance and Appeals Procedures Article of this Benefit Plan. The Plan Participant or the Provider may appeal the denial by contacting the Claims Administrator in writing within one hundred eighty (180) days of notice of the denial in accordance with the Complaints, Grievance and Appeals Procedures Article of this Benefit Plan.
- b. If the Claims Administrator does not reverse the decision, the Plan Participant will be responsible for (and no Benefits will be payable for) charges incurred.
- c. Providers will be notified of appeal results only if the Provider filed the appeal.

B. Disease Management

1. Qualification

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

2. Disease Management Benefits

Blue Cross Blue Shield of Louisiana's Disease Management s are committed to improving the quality of care for Plan Participants as well as decreasing health care costs in populations with one or more of these five (5) chronic health conditions – diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD).

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

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

To remain eligible for the Plan program, Plan Participants must maintain a continuing relationship with the BCBSLA health coach that includes a telephone call at least once every three months.

C. Case Management

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 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 and 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, co-insurance and Fee Schedule.
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 plan.

7. Mental health and substance abuse treatments/conditions are not eligible for Case Management.
8. The Claims Administrator must be the primary carrier at the time of enrollment in Case Management.
9. The Plan Participant may not be confined in any type of nursing home setting at the time of enrollment in Case Management.

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 and that are not normally covered. To be eligible, the illness or injury must be a covered condition under the Plan. The 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, co-insurance and Fee Schedule.
4. Alternative Benefits provided under this Article are provided in lieu of the Benefits to which the Plan Participant is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Plan.
5. The Plan Participant's Alternative Benefits will be terminated upon any of the following occurrences:
 - a. The Claims Administrator determines, in their sole discretion, that the Plan Participant is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.
 - b. The Plan Participant receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by the Claims Administrator.
6. The Claims Administrator must be the primary carrier at the time of request for Alternative Benefits.

ARTICLE XVII.

LIMITATIONS AND EXCLUSIONS

A. No benefits are provided under this Plan for the following:

1. Injury compensable under any worker's compensation, 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. 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;
3. Expenses for elective, non-therapeutic voluntary abortions (abortions performed for reasons other than to save the life of the mother);
4. Injuries sustained by a Covered Person while in an aggressor role;
5. Expenses incurred as a result of a Covered Person's commission or attempted commission of an illegal act;
6. 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 a 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;
7. Shoes and related items, such as wedges, cookies, and arch supports;
8. 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 the 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 and maxillofacial surgeries which are shown to the satisfaction of the Claims Administrator to be Medically Necessary, non-dental, non-cosmetic procedures;
9. Medical services, supplies, treatments, and prescription drugs provided without charge to the Plan Participant or for which the Plan Participant is not legally obligated to pay;
10. Maternity expenses incurred by any person other than the Employee or the Employee's legal Spouse;
11. 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;

12. Charges for services, supplies, treatment, drugs, and devices which are in excess of the maximum allowable under the Medical Fee Schedule, Outpatient Surgical Facility Fee Schedule, or any other limitations of the Plan;
13. Services, supplies, treatment, drugs, devices, and deluxe medical equipment which are not deemed Medically Necessary by the Claims Administrator;
14. Services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, pain rehabilitation control and/or therapy, and dietary or educational instruction for all diseases and/or illnesses, except diabetes;
15. Services and supplies for the treatment of and/or related to gender dysphoria or reverse sterilization;
16. 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;
17. 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;
18. 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, and any items the Claims Administrator determines are not medical supplies;
19. Administrative fees, interest, penalties, or sales tax;
20. Marriage counseling, family relations counseling, divorce counseling, parental counseling, job counseling, and career counseling;
21. Charges for Physician services rendered to a Plan Participant over the telephone or in a non-face-to-face setting;
22. Radial keratotomy, laser surgery, and any other procedures, services, or supplies for the correction of refractive errors of the eyes;
23. Services, supplies, surgeries, and treatments for excess body fat, resection of excess skin and/or fat following weight loss or pregnancy, and/or obesity, and morbid obesity.

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

24. Hearing aids and any examination to determine the fitting or necessity of hearing aids, except as specifically provided for in this Benefit Plan;
25. Hair plugs and/or transplants;

26. Routine physical examinations and/or immunizations not provided for under this Benefit Plan;
27. Routine eye examinations, glasses, and contact lenses, except as specifically provided for in this Benefit Plan;
28. Diagnostic or treatment measures that are not recognized as generally accepted medical practice;
29. Medical supplies not specifically provided for in this Benefit Plan;
30. Treatment or services for mental health and substance abuse provided outside the treatment plan developed by the contracted behavioral health Provider or Non-network Providers;
31. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or required by law.
32. Services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.);
33. Services rendered by a Physician or other health care Provider related to the patient by blood, adoption, or marriage;
34. Expenses for services rendered by a Physician or other health care Provider who is not licensed in the state where such services are rendered or in any facility not holding a valid license in the state and for the services rendered;
35. 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;
36. Glucometers;
37. Augmentative communication devices;
38. Charges to obtain medical records or any other information needed and/or required to adjudicate a claim;
39. Charges greater than the global allowance for any laboratory, pathology, or radiological procedure.
40. Services of a licensed speech therapist when services are not prescribed by a Physician and prior authorization is not obtained.
41. 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.

ARTICLE XVIII.

COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits (COB) section applies to This Plan when a Plan Participant has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.

2. If this COB section applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the Benefits of This Plan are determined before or after those of another plan. The Benefits of This Plan:
 - a. will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its Benefits before another plan.
 - b. may be reduced when under the Order of Benefit Determination Rules, another plan determines its Benefits first. That reduction is described in Section D. of this COB section, "Effect on the Benefits of This Plan."
3. When Benefits are available for prescription drugs, the Claims Administrator does not coordinate Benefits for Prescription Drug Claims, except for Claims that are subject to Medicare Part D and Medicare Secondary Payor requirements.

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

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

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

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

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

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

are determined after those of the other plan and may be reduced because of the other plan's Benefits.

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

4. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the Claim is made.

When a plan provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

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

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

C. Order of Benefit Determination Rules

1. When there is a basis for a Claim under This Plan and another plan, This Plan is a Secondary Plan which has its Benefits determined after those of the other plan, unless:
 - a. the other plan has rules coordinating its Benefits with those of This Plan; and,
 - b. both those rules and This Plan's rules, in paragraph 2. below, require that This Plan's Benefits be determined before those of the other plan.
2. This Plan determines its order of Benefits using the first of the following rules which applies:
 - a. Non-Dependent/Dependent: The Benefits of the Plan which covers the person as an Employee, (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - (1) Secondary to the plan covering the person as a Dependent, and
 - (2) Primary to the plan covering the person as other than a Dependent (e.g., a retired Employee), then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.
 - b. Dependent Child/Parents Not Separated or Divorced: Except as stated in paragraph 2(c) below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents:"
 - (1) the Benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the calendar year; but
 - (2) if both parents have the same birthday, the Benefits of the plan which covered one parent longer are determined before those of the plan, which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a)

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

- c. **Dependent Child/Separated or Divorced Parents:** If two (2) or more plans cover a person who is a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:

- (1) first, the plan of the parent with custody of the child;
- (2) then, the plan of the spouse of the parent with custody of the child; and
- (3) finally, the plan of the parent not having custody of the child.

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

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

- d. **Joint Custody:** If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of Benefit determination rules outlined in Section C. 2. b, above.

- e. **Active/Inactive Employee:** The Benefits of a plan which covers a person as an Employee who is not terminated, laid off, or retired (or as that Employee's Dependent) are determined before those of a plan which covers that person as a terminated, laid off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

- f. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of Benefit determination:

- (1) first, the Benefits of a plan covering the person as an Employee or their Dependent;
- (2) Second, the Benefits under the continuation coverage.

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

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

D. Effects on the Benefits of This Plan

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

2. Reduction in This Plan's Benefits

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

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

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

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

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

G. Right of Recovery

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

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

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

ARTICLE XIX. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

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

A. The 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 imposed on the Employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the Plan Administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those specifically undertaken by Us herein. To the extent this Benefit Plan 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. We will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.
3. The (Plan Administrator) shall administer the Benefit Plan in accordance with its terms and establishes its policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its employees and Dependents, to decide disputes which may arise relative to a Subscriber's rights, and to decide questions of plan interpretation and those of fact relating to the plan. The decisions of the Plan Administrator will be final and binding on all interested parties.
4. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, health care Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

B. Amending and Terminating the Benefit Plan

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

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

C. Identification Cards and Benefit Plans

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

D. Benefits Which Plan Participants are Entitled

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.
2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.
3. The Claims Administrator may set a minimum dollar amount for Claims to be reviewed for possible Pre-Existing Conditions.

E. Termination of a Plan Participant's Coverage

1. The Plan may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment. All representations made are material to the issuance of this coverage. Any information 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.
2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, an Employee's coverage terminates as provided below:
 - a. The Employee's coverage and that of all his Dependents automatically, and without notice, terminates at the date of the termination date.
 - b. The coverage of the Employee's spouse will terminate automatically, and without notice the date of a final decree of divorce or other legal termination of marriage.
 - c. The coverage of a Dependent will terminate automatically, and without notice, the date the Dependent ceases to be an eligible Dependent.
 - d. Upon the death of an Employee, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if premiums have been paid through that period the date that death occurred. However, a surviving spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.
3. In the event the Group cancels this Benefit Plan, such cancellation or termination alone will operate to terminate all rights of the Plan Participant to Benefits under the terms of this Benefit Plan as of the effective date of such cancellation or termination. Group shall have the obligation to notify its Subscribers, participants, and beneficiaries of such cancellation or termination. The Claims Administrator shall have no such obligation of notification at the Plan Participant level.
4. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Plan Participant for Covered Services rendered after the date of termination of a Plan Participant's coverage.

5. The Claims Administrator reserves the right to automatically change the Plan Participant's class of coverage to reflect when no more Dependents are covered under this Benefit Plan.

F. Filing Claims

1. A Claim is a written or electronic proof of charges for Covered Services that a Plan Participant has incurred during the time-period he was covered under this Plan. The Plan encourages Providers to file claims in a form acceptable to the Claims Administrator within ninety (90) days from the date services are rendered, but no later than twelve (12) months after the date of service. 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.

G. Applicable Law

This Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law. This Plan is not subject to regulation by any state other than the State of Louisiana. If any provision of this Benefit Plan is in conflict with **any applicable** statutes or regulations of the U.S. or the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute or regulation.

H. Time Limit for Legal Action

No lawsuit may be filed:

- any earlier than the first sixty (60) days after notice of Claim has been given; or
- any later than twelve (12) months after the date services are rendered.

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

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. Except as provided in Subsection C (below), when an individual is covered by this Plan and by Medicare, and:
 - a. this Plan is the primary payer, Benefits will be paid without regard to Medicare coverage;
 - b. 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. All provisions of this Plan, including all provisions related to Deductibles, Coinsurance, limitations and exclusions will be applied.
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. upon attainment of age sixty-five (65), a Retiree and/or the Retiree's spouse may be eligible for Medicare if the Retiree or Retiree's spouse has sufficient earnings credits;
 - b. 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 except as specifically provided in paragraph 3, below;
 - c. 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;
 - d. a Retiree and spouse of a Retiree who do not have sufficient earnings credits to be eligible for Medicare must provide written verification from the Social Security Administration or its successor.
3. Retiree 100-Medicare COB – Upon enrollment and payment of the additional monthly premium, a Plan Member and Dependents who are covered under Medicare Parts A and B (both) may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare, within 30 days of retirement if already eligible for Medicare, or at annual enrollment.

L. Notice

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

M. Job-Related Injury or Illness

The Group must report to the appropriate governmental agency any job-related injury or illness of an Employee where so required under the provisions of any legislation of any governmental unit. This Plan, with certain described exceptions, excludes Benefits for any services covered in whole or in part by Workers' Compensation laws and/or rendered as a result of occupational disease or injury, subject to the provisions of La. R.S. 23:1205(C). In the event Benefits are initially extended by the Plan and a

compensation carrier or employer makes any type of settlement with the Employee, or with any person entitled to receive settlement where the Employee dies, or if the Employee's injury or illness is found to be compensable under law, the Employee must reimburse the Plan for Benefits extended or direct the compensation carrier to make such reimbursement. The Group will be entitled to such reimbursement even if the settlement does not mention or excludes payment for health care expenses.

N. Subrogation

Upon payment of any eligible Benefits covered under this Plan, the Office of Group Benefits shall succeed and be subrogated to all rights of recovery of the covered Employee, his Dependents or other Covered Persons, or their heirs or assigns, for whose benefit payment is made, and they shall execute and deliver instruments and papers and do whatever is necessary to secure such rights, and shall do nothing after loss to prejudice such rights.

The Office of Group Benefits has an automatic lien against and shall be entitled, to the extent of any payment made to a covered Employee, his Dependents or other Covered Persons, to 100% of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a covered Employee, his Dependents or other Covered Persons, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made.

To this end, covered Employees, their Dependents, or other Covered Persons agree to immediately notify the Office of Group Benefits 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 when a Covered Person recovers under, BUT NOT LIMITED TO, 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 to first recovery to the extent of any judgment, settlement, or any payment made to the covered Employee, his Dependents or other Covered Persons. These rights apply regardless of whether such recovery is designated as payment for, but not limited to, pain and suffering, medical benefits, or other specified damages, even if he is not made whole (i.e., fully compensated for his injuries).

O. Right of Recovery

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

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

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

The United States will have the right to collect from the Plan the reasonable cost of health care services incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that the Retiree or Dependent would be eligible to

receive reimbursement or indemnification from the Plan if the Retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

Q. Liability of Plan Affiliates

The Plan Administrator, on behalf of itself and its participants, hereby expressly acknowledges its understanding that the Claims Administrator is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Blue Cross and Blue Shield of Louisiana and its subsidiaries and affiliates (collectively "Blue Cross and Blue Shield of Louisiana") to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that the Claims Administrator is not contracting as the agent of the Association. The Plan Administrator, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Plan Administrator for any of Blue Cross and Blue Shield of Louisiana's obligations to the Plan.

This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of the claims administration agreement.

R. Out-of-Area Services

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

Typically, when accessing care outside Blue Cross and Blue Shield of Louisiana's service area, Plan Participants will obtain care from healthcare Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Plan Participants may obtain care from Non-Participating healthcare Providers. Claims Administrator's payment practices in both instances are described below.

1. BlueCard®

Under the BlueCard®, 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 Participating healthcare Providers.

Whenever Plan Participants access covered healthcare services outside Blue Cross and Blue Shield of Louisiana's service area and the claim is processed through the BlueCard®, the amount Plan Participants pay for covered healthcare services from Participating Providers 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 the healthcare Provider or Provider group that may include types of

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

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

Laws in a small number of states may require the Host Blue to add a surcharge to a calculation. If any state laws mandate other liability calculation methods, including a surcharge, Claims Administrator would then calculate your liability for any covered healthcare services according to applicable law.

2. Medicare Supplemental/Medigap/Medicare Complementary

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

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

3. Non-Participating Healthcare Providers outside Blue Cross and Blue Shield of Louisiana's Service Area

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

a. Plan Participant Liability Calculation

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

b. Exceptions

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

Provider payment), or in Claims Administrator's sole and absolute discretion, it may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Plan Participant may be responsible for the difference between the amount that the Non-Participating healthcare Provider bills and payment the Claims Administrator will make for the covered services as set forth in this paragraph.

c. **Medigap/Medicare Supplemental/Medicare Complementary Plans**

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

S. HIPAA Certificates of Creditable Coverage

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

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

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

Claims 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. Claims Administrator will provide these Certificates to covered Group Plan Participants who are eligible for Medicare Part D based upon enrollment data. Plan Administrator is responsible for providing a certificate to applicants prior to the Effective Date of coverage for new Medicare-eligible persons that join this Plan.

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

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

U. Compliance with HIPAA Privacy Standards

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

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

1. General

The Plan shall not disclose Protected Health Information to any Plan Participant of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

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

3. Authorized Employees

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

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

4. Certification of Employer

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

- a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
- b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Employer;
- d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;
- f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

- h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- j. ensure the adequate separation between the Plan and Plan Participant of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

The following Plan Participants of the State of Louisiana Office of Group Benefits workforce are designated as authorized to receive Protected Health Information from Office of Group Benefits ("the Plan") in order to perform their duties with respect to the Plan:

- OGB Customer Service management and representatives
- OGB Agency Services management and representatives
- OGB Eligibility Services management and representatives
- OGB Executive Staff
- OGB Contract Manager and Reviewer
- OGB IT Supervisors
- OGB Legal Services management and representatives
- OGB Medical Director and Nursing Staff
- OGB Provider Relations supervisors
- OGB Claims management and representatives

V. Compliance with HIPAA Electronic Security Standards

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

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

ARTICLE XX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

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.

COMPLAINTS

A Complaint is an **oral** expression of dissatisfaction with the *quality of care or services* received from the Claims Administrator or a network Provider. For example, services, access, availability, or attitude of the Claims Administrator or a network Provider. **To make a Complaint**, call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370. 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.

GRIEVANCES

A Grievance is a **written** expression of dissatisfaction with the *quality of care or services* received from the Claims Administrator or a network Provider. **To file a first level Grievance**, send the first level Grievance to:

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

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

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

If the Plan Participant or his Authorized Representative is dissatisfied with the Claims Administrator's response to the first level Grievance, he has the right to file a second level Grievance. **To file a second level Grievance**, send the second level Grievance to:

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

A second level Grievance must be received by the Claims Administrator within **sixty (60) calendar days** from the date of the Claims Administrator's response to the first level Grievance.

A separate panel reviews each level of Grievance.

A. Appeals: Coverage Decisions

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

A Plan Participant's appeal rights, including a right to an **expedited** appeal, are outlined below. In addition to the appeal rights, the Plan Participant's Provider may initiate an Informal Reconsideration to review *Utilization Management decisions*.

INFORMAL RECONSIDERATION

An Informal Reconsideration is a process to review *Utilization Management decisions* and is initiated by a telephone request from the Plan Participant's Provider to the Claims Administrator's Medical Director or to a peer reviewer. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion. An Informal Reconsideration is available only if requested within **ten (10) calendar days** of the date of the initial denial or adverse Concurrent Review determination. The Claims Administrator will conduct the Informal Reconsideration within **one (1) business day** from the receipt of the request. Once the Informal Reconsideration is complete, the Claims Administrator will advise the Plan Participant or his Authorized Representative of the decision and, if necessary, the Plan Participant's additional appeal rights.

APPEAL PROCESS

An Appeal is a **written** expression of dissatisfaction with *coverage decisions* made by the Claims Administrator. An appeal may be filed by a Plan Participant or his Authorized Representative. 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 1-800-599-2583 or 1-225-291-5370.

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

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

First Level Appeals

The Plan Participant or his Authorized Representative has **one hundred eighty (180) calendar days** from receipt of the notice of an adverse benefit determination to file a first level Appeal. **To file a first level Appeal**, send the first level Appeal to:

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

If the Claims Administrator grants the first level Appeal, the Claims Administrator will reprocess the claim.

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

If the first level Appeal is denied or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative may file a second level Appeal.

Second Level Appeals: EXCEPT Medical Necessity and Investigational

The Plan Participant or his Authorized Representative has **sixty (60) calendar days** from receipt of the notice denying the first level Appeal to file a second level Appeal. **To file a second level Appeal**, send the second level Appeal to:

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

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

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

If the second level Appeal is denied or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, the Plan Participant or his Authorized Representative may file an OGB voluntary level Appeal, **provided** the coverage decision is **not** one of *Medical Necessity* or *Investigational*. If the appeal involves rescission of coverage or medical judgment, then the Plan Participant **also** has a right to request an external review.

Second Level Appeals: Medical Necessity ONLY

If the Plan Participant is dissatisfied with a *Medical Necessity coverage decision*, the Plan Participant or his Authorized Representative has a right to file a second level Medical Necessity Appeal. For the second level Medical Necessity Appeal, the Plan Participant may choose an internal review by an appeal review committee or an external review by an Independent Review Organization (IRO). **To file a second level Medical Necessity Appeal**, complete the Claims Administrator's "Request for Appeal Form" and send it to:

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

Internal Review: The Plan Participant must file the request for an internal review within **sixty (60) calendar days** following the Plan Participant's receipt of the first level Appeal denial. The internal review process allows the Plan Participant to attend the meeting and present additional material and/or provide testimony.

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

If the internal review committee denies the second level Medical Necessity Appeal 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 an external review by an IRO as described in the section titled “**EXTERNAL REVIEW RIGHT: Appeals Involving Rescission of Coverage and Medical Judgment.**”

External Review: See section titled “**EXTERNAL REVIEW RIGHT: Appeals Involving Rescission of Coverage and Medical Judgment.**”

Second Level Appeals: Investigational ONLY

If the Plan Participant is dissatisfied with an *Investigational coverage decision*, the Plan Participant or his Authorized Representative has a right to file a second level Investigational Appeal. The second level Investigational Appeal is an external review by an Independent Review Organization (IRO). The Plan Participant or his Authorized Representative has **sixty (60) calendar days** from receipt of the notice denying the first level Appeal to file a second level Investigational Appeal. **To file a second level Investigational Appeal**, complete the Claims Administrator’s “Request for Appeal Form” and send it to:

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

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

If an external review right exists, the Claims Administrator will provide the IRO all pertinent information necessary to conduct the review. The IRO decision will be considered a final and binding decision on both the Plan Participant and the Claims Administrator. The IRO will notify the Plan Participant or his Authorized Representative, and the Claims Administrator, in writing, of the decision within forty-five (45) calendar days from the date the IRO received the external review request from the Claims Administrator.

OGB Voluntary Level Appeal

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

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

along with copies of all information relevant to the Appeal. The Plan Participant or his Authorized Representative is entitled to receive free of charge, copies of all information relevant to the Appeal from the Claims Administrator (Blue Cross and Blue Shield of Louisiana, Claims Administrator, Appeals and Grievance Unit, P. O. Box 98045, Baton Rouge, LA 70898-9045).

If the Administrative Claims Committee (ACC) grants the OGB voluntary level Appeal, the Claims Administrator will reprocess the claim. If the ACC denies the OGB voluntary level Appeal, the ACC

will notify the Plan Participant or his Authorized Representative, in writing, of the decision within sixty (60) calendar days from the date the ACC received the OGB voluntary level Appeal, or as allowed by law.

EXTERNAL REVIEW RIGHT: Appeals Involving Rescission of Coverage and Medical Judgment

If the second level Appeal is denied or if the Claims Administrator fails to complete the Appeal within the time limits set forth above, **and** the appeal involves rescission of coverage or medical judgment, then the Plan Participant has a right to request an external review by an Independent Review Organization (IRO).

The Plan Participant or his Authorized Representative has **one hundred twenty (120) calendar days** from receipt of the notice denying the second level Appeal, or **one hundred eighty (180) calendar days** from receipt of the notice denying the first level Appeal to request an external review. **To request an external review**, send the request to:

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

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

If an external review right exists, the Claims Administrator will provide the IRO all pertinent information necessary to conduct the review. The IRO decision will be considered a final and binding decision on both the Plan Participant and the Claims Administrator. The IRO will notify the Plan Participant or his Authorized Representative, and the Claims Administrator, in writing, of the decision within forty-five (45) calendar days from the date the IRO received the external review request from the Claims Administrator.

EXPEDITED APPEALS

The Expedited Appeal process is a process to review of *coverage decisions* when the time frame of the appeal process described above would seriously jeopardize the Plan Participant's life, health, and ability to regain maximum function; or, when, in the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a decision through the appeal process described above. For example, a request concerning an admission, availability of care, continued stay, or health care service for a Plan Participant who is requesting Emergency services, has received Emergency services but has not been discharged from a facility, or has been admitted to the facility.

First Level Expedited Appeal

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

To file a first level Expedited Appeal, contact:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal - Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045
1-800-599-2583 or 1-225-291-5370

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

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

Second Level Expedited Appeal

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

Blue Cross and Blue Shield of Louisiana
Expedited Appeal - Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045
1-800-599-2583 or 1-225-291-5370

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

B. 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 second level Expedited Appeal process;
- The second level Appeal process;
- The OGB voluntary level Appeal; or
- The external review process.

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

C. Legal Limitations

A Plan Participant must exhaust his administrative remedies before filing a legal action. No legal action shall be brought against the Plan to attempt to recover benefits under this Plan more than one year after the time a claim is required to be filed, or more than thirty (30) days after the Plan Participant has exhausted his administrative remedies, whichever is later.

ARTICLE XXI.

HOW TO OBTAIN CARE WHILE TRAVELING, MAKE PLAN CHANGES AND FILE CLAIMS

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

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

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

A. How to Obtain Care While Traveling

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

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

B. How to File Claims for Benefits

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

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

1. an appropriate claim form is used

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

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

C. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

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

2. Emergency Room or Outpatient Department Claims

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

3. Nursing Services Claims

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

4. Durable Medical Equipment (DME) Claims

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

5. Mental Health and/or Substance Abuse Claims

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

6. Other Medical Claims

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

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

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

D. If Plan Participant Has a Question about His Claim

If a Plan Participant has a question about the payment of a Claim, the Plan Participant can write to the Claims Administrator at the address below or the Plan Participant may call the Claims Administrator's customer service department at the telephone number shown on his ID card or any of the Claims Administrator's local service offices*.

If the Plan Participant calls for information about a Claim, the Claims Administrator can help the Plan Participant better if the Plan Participant has the information at hand, particularly the contract number, patient's name and date of service.

Blue Cross and Blue Shield of Louisiana,
5525 Reitz Avenue
Baton Rouge, LA 70898-9029

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

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

ARTICLE XXII.

RESPONSIBILITIES OF PLAN ADMINISTRATION

A. Plan Administrator

The Office of Group Benefits is the Benefit Plan of State of Louisiana Office of Group Benefits, the Plan Administrator, also called the Plan Administrator. It is to be administered by the Plan Administrator. An individual may be appointed by the State of Louisiana Office of Group Benefits to be the Plan Administrator and serve at the convenience of the Employer.

If the Plan Administrator resigns, dies or is otherwise removed from the position, State of Louisiana Office of Group Benefits shall appoint a new Plan Administrator as soon as reasonably possible.

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

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

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

B. Duties of the Plan Administrator

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

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.

1. Fiduciary Duties

A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to the employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

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

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: Office of Group Benefits
Preferred Provider Organization Health Plan for State of Louisiana Employee and Retirees

NAME AND ADDRESS OF EMPLOYER/PLAN ADMINISTRATOR: State of Louisiana Office of Group Benefits
Post Office Box 44036
Baton Rouge, Louisiana 70804

PLAN NUMBER (PN): 501

TYPE OF PLAN: Group Major Medical Benefit Plan

FUNDING MEDIUM AND TYPE OF ADMINISTRATION: The Plan is a self-funded Group Health Plan. Benefits are administered, on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administrative Services Agreement and the terms and conditions of the Benefit Plan.

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

PLAN ADMINISTRATOR: State of Louisiana Office of Group Benefits
Post Office Box 44036
Baton Rouge, Louisiana 70804
(225) 925-6625 or (225) 925-6770 (TDD)
(800) 272-8451 or (800) 259-6771 (TDD)

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

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

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

PLAN YEAR ENDS: December 31st

PLAN DETAILS: The eligibility requirements, termination provisions and a description of the circumstances which may result in

disqualification, ineligibility, denial, or loss of any Benefits are described in the Benefit Plan.

FUTURE OF THE PLAN:

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

