



Group Health Benefit Plan
PPO Group Care

40XX0492 R01/14



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

GROUPCARE
GROUP HEALTH BENEFIT PLAN

NOTICES

Your Group plan administrator and Blue Cross and Blue Shield of Louisiana believe this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on Benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Your plan administrator or to Blue Cross and Blue Shield of Louisiana at the telephone number on the back of Your ID card. ERISA members may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Members who are not on ERISA plans may contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Plan sponsors of grandfathered benefit plans are required by law to notify the Group Underwriting Department of Blue Cross and Blue Shield of Louisiana immediately, if Your contribution rate toward the insurance premium for this coverage changes at any point during the Plan Year.

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. 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.

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

We base Our payment of Benefits for the Member's covered services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom a Member receives 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

GROUPCARE
GROUP HEALTH BENEFIT PLAN

PRESCRIPTION DRUG FORMULARY

NOTICES

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

This insurance policy covers Prescription Drugs and uses an open Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this insurance policy. With an open formulary, Company automatically includes new Prescription Drugs to Your coverage when drug manufacturers release these new drugs for sale. Placement of Prescription Drugs on a drug tier may be based on a drug's quality, safety, clinical efficacy, available alternatives, and cost. Company reviews the Prescription Drug Formulary at least once per year.

Information about Your formulary is available to You in several ways. Most Members receive information from Us in the mail about their Prescription Drug coverage, including information about specific drugs, cost, and drug lists. We also have information available for You to print and discuss with Your doctor. You can review and print formulary information immediately from Our website, www.bcbsla.com.

You may also contact Us at the telephone number on Your ID card to ask whether a specific drug is included in Your formulary. If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your Physician or other authorized prescriber will prescribe the drug for a particular medical condition or mental illness. You may file a written Appeal to Us if a Prescription Drug is not included in the formulary and Your Physician or authorized prescriber has determined that the drug is Medically Necessary for You. Instructions for filing an Appeal are included in this policy.

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

You have the right to continue the coverage of any Prescription Drug that was approved or covered by Us for a medical condition or mental illness, at the contracted Benefit level until the renewal of Your current insurance coverage regardless of whether the drug has been removed from Your formulary. Your Physician or other authorized prescriber may prescribe a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug is covered under the health plan and is medically appropriate for You.

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

Blue Cross and Blue Shield of Louisiana (Company) issues this health Benefit Plan to the Group/Policyholder shown in the Schedule of Benefits. A copy of this Benefit Plan provided to Subscribers serves as the Subscriber's certificate of coverage. As of the Benefit Plan Date shown in the Group's Schedule of Benefits, We agree to provide the Benefits specified herein for Subscribers of the Group and their enrolled Dependents. This Benefit Plan replaces any others previously issued to the Group/Policyholder, as of 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. We encourage You to read this Benefit Plan carefully.

You should call Us 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, We use common words 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 Subscriber 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. Members have an extensive Provider Network available to them – Blue Cross and Blue Shield of Louisiana's Preferred Care (PCare) PPO Network. Members can also get care from Providers who are not in this Network, but Benefits will be paid at a lower level of Benefits. Additionally, a Non-Participating Hospital penalty may apply when Members receive care from a Hospital outside of the Network.

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

Most Benefits are subject to the Member's payment of a Deductible as stated in the Schedule of Benefits. After payment of applicable Deductibles, Benefits are subject to two (2) Coinsurance levels (for example: 80/20, 60/40). The Member's choice of a Provider determines what Coinsurance level applies to the service provided. We will pay the highest Coinsurance level for Medically Necessary services when a Member obtains care from a Provider in the Preferred Care PPO Network. We will pay the lower Coinsurance level when a Member obtains Medically Necessary services from a Provider who is not in the Preferred Care PPO Network.

OUR PROVIDER NETWORK

Members choose which Providers will render their care. This choice will determine the amount We pay and the amount the Member pays for Covered Services.

Our Preferred Care PPO (or PCare) Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with Us to participate in the Blue Cross and Blue Shield of Louisiana PPO Provider Network and render services to Our Members. We call these Providers "PPO Providers," "Preferred Providers," or "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 Member should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Care Provider before the service is rendered. Members may review a current paper Provider directory, check on-line at www.bcbsla.com, or contact Our Customer Service Department at the number listed on their ID card.

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

A Provider may be contracted with Us when providing services at one location, and may be considered Out-of-Network when rendering services from another location. The Member 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 Us 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 Member 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 CARE NETWORK

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

We pay a lower level of Benefits when a Member uses a Provider outside the Preferred Care Network. Benefits may be based on a lower Allowable Charge, and/or a penalty may apply. Care obtained outside Our Network means the Member 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, We only pay a portion of those charges and it is Your responsibility to pay the remainder. The amount You are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum.

We recommend that You ask Non-Network Providers to explain their billed charges to You, BEFORE You receive care 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 Us 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 We Authorize these services and the services are rendered by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or a transplant facility in Our Blue Cross and Blue Shield PPO Provider Network, unless otherwise approved by Us in writing. To locate an approved transplant facility, Members should contact Our Customer Service Department at the number listed on their ID card.

HOW WE DETERMINE WHAT WE PAY FOR COVERED SERVICES

When a Member Uses Preferred (PPO) Providers

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

When a Member Uses Participating Providers

Participating Providers are Providers who have signed contracts with the Company or another Blue Cross and Blue Shield plan for other than a Preferred Care or PPO 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 Member. This amount is the Participating Provider's Allowable Charge. When a Member uses a Participating Provider, this Allowable Charge is used to determine the amount the Company pays for Medically Necessary Covered Services and the amount the Member pays.

When a Member Uses Non-Participating Providers

Non-Participating Providers are Providers who have not signed any contract with the Company or any other Blue Cross and Blue Shield plan to participate in any Blue Cross and Blue Shield Network.

These Providers are not in Our Networks. We have no fee arrangements with them. The Company establishes an Allowable Charge for Covered Services provided by Non-Participating Providers. We use the lesser of the Provider's actual billed charge or the established Allowable Charge to determine what to pay for a Member's Covered Services when the Member receives care from a Non-Participating Provider. The Member will receive a lower level of Benefit because he did not receive care from a Preferred Provider. Additionally, a thirty percent (30%) penalty may apply when the Non-Participating Provider is a Hospital.

The Member 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 and Participating Providers waive the difference between their actual billed charge and their Allowable Charge, while Non-Participating Providers will not.

If Covered Services are received from a Non-Participating Hospital because these services were not available from a Preferred or Participating Hospital within a seventy-five (75) mile radius of the Member's home, the Company will not apply the thirty percent (30%) Non-Participating Hospital penalty. If Emergency Medical Services are received from a Non-Participating Hospital, the Company will not apply the thirty percent (30%) Non-Participating Hospital penalty to the Hospital's Emergency Room charges.

The Member has the right to file an Appeal with the Company for consideration of a higher level of Benefits if the Member 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 Member's home. To file an Appeal, the Member must follow the Appeal procedures set forth in this Benefit Plan.

SAMPLE ILLUSTRATION OF MEMBER 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 Member's actual Copayments, Deductible and Coinsurance amounts. Please refer to the Schedule of Benefits to determine Your Benefits.

EXAMPLE: A Member has a PPO policy with a \$500 Deductible Amount. The Member has 80/20 Coinsurance when the Member receives Covered Services from Hospitals in the PPO Network and 60/40 Coinsurance when the Member receives Covered Services from Hospitals that are not in the PPO Network. Assume the Member 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 PPO 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. A thirty percent (30%) Non-Participating Hospital penalty may apply, and the Member is responsible for all amounts not paid by the Company, up to the Provider's billed charge.

The Member receives Covered Services from:	Preferred 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
<i>Non-Participating Hospital Penalty may apply:</i>			\$750 (30% x \$2,500)
We pay:	\$2,000 \$2,500 Allowable Charge x 80% Coinsurance = \$2,000	\$1,800 \$3,000 Allowable Charge x 60% Coinsurance = \$1,800	\$1,050 \$2,500 Allowable Charge - \$750 penalty = \$1,750 x 60% Coinsurance = \$1,050
Member pays:	\$500 20% Coinsurance x \$2500 Allowable Charge = \$500	\$1,200 40% Coinsurance x \$3,000 Allowable Charge = \$1,200	\$1,450 \$750 Hospital Penalty + 40% Coinsurance (\$1,750 x 40% = \$700)
Is Member billed up to the Provider's billed charge?	NO	NO	YES - \$9,500, for a total of:
TOTAL MEMBER PAYS:	\$500	\$1,200	\$10,950

WHEN A MEMBER PURCHASES COVERED PRESCRIPTION DRUGS

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

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

WHEN A MEMBER RECEIVES MENTAL HEALTH, SUBSTANCE ABUSE BENEFITS

The Company has contracted with an outside company to perform certain administrative services related to Mental Health and substance abuse services for Our Members. For help with these Benefits, the Member should refer to his Schedule of Benefits, his Identification Card, or call Our Customer Service Department.

ASSIGNMENT

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

MEMBER INCENTIVES

Sometimes We may offer coupons, discounts, or other incentives to encourage Members to participate in various programs such as pharmacy programs, wellness programs, or disease management programs. A Member may wish to decide whether to participate after discussing such programs with their Physicians. These incentives are not Benefits and do not alter or affect Member Benefits.

We, Blue Cross and Blue Shield of Louisiana, offer Members a wide range of health management and wellness tools and resources. Members can use these tools to manage their personal accounts, create health records and access a host of online wellness interactive tools. Members also have access to a comprehensive wellness program that includes a personal health assessment and customized health report to assess any risks based on his history and habits. Exclusive discounts are also available to members on some health services such as fitness club memberships, diet and weight control programs, vision and hearing care and more.

CUSTOMER SERVICE E-MAIL ADDRESS

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

ARTICLE II.

DEFINITIONS

Accidental Injury – A condition 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.

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

Allied Health Professional – A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, and/or approved by the Company 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 the Company 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 Company 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 Company may agree to provide when it is beneficial both to the Member and to Us.

Ambulance Service – Medically Necessary transportation by a specially designed emergency vehicle for transporting the sick and injured. The vehicle must be equipped as an emergency transport vehicle and staffed by trained ambulance personnel as required by appropriate State and local laws governing an emergency transportation vehicle.

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

Appeal – A request from a Member or authorized representative to change a previous decision made by the Company about Covered Services. 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 Company, of equivalent education, professional training, and supervised experience in ABA.

Authorization (Authorized) – A determination by the Company 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 Member's choice of Provider.

Autism Spectrum Disorders (ASD) – Any of the pervasive development disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM). These disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. ASD includes 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 Benefit Plan. Benefits provided by the Company are based on the Allowable Charge for Covered Services.

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

Benefit Plan – This agreement, including the Application for Group Coverage, the Schedule of Benefits and amendments/endorsements, if any, entitling the Subscriber and covered Dependents to specified health care coverage.

Benefit Plan Date – The date upon which the Company issued this Benefit Plan to the Group.

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 We identify as a Brand-Name product. We classify 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 Us.

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

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 Company, of charges for Covered Services that have been incurred by a Member during the time period the Member 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.

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.

Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a pair of percentages, a Company percentage that We pay, and a Member percentage that You pay. Once the Member has met any applicable Deductible Amount, the Member's percentage will be applied to the Allowable Charges for Covered Services to determine the Member's financial responsibility. The Company'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 health plan or Provider services.

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

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

Congenital Anomaly – A condition existing at or from birth, which significantly interferes with normal bodily function. For purposes of this Benefit Plan, the Company 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 Member, 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.

Copayment (Copay) – The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider.

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

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to: personal care, homemaking, moving the patient; acting as companion or sitter; supervising medication that can usually be self-administered; treatment or services that any person may be able to perform with minimal instruction; or long-term treatment for a condition in a patient who is not expected to improve or recover. The Company determines which services are Custodial Care.

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

Deductible Amount

A. Benefit Period Deductible Amount

The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Member must pay within a Benefit Period before the Benefit 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 Members in a class of coverage with more than one (1) Member, this aggregate amount shown in the Schedule of Benefits is the maximum deductible amount that a family must pay before this Contract starts paying Benefits. Once a family has met its Family Deductible Amount, this Contract starts paying Benefits for all Members of the family, regardless of whether each individual family Member has met his individual Benefit Period Deductible. No family Member may contribute more than his Benefit Period Deductible Amount to satisfy the aggregate deductible amount required of a family amount required of a family. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan. Only Benefit Period Deductible Amounts accrue to the Family Deductible Amount.

C. Inpatient Hospital Deductible Amount

The dollar amount, if shown in the Schedule of Benefits, of charges for Covered Services rendered by a Hospital, which a Member must pay for each Admission. This Inpatient Hospital Deductible Amount may be waived for certain Hospitals, if shown in the Schedule of Benefits.

1. The Inpatient Hospital Deductible Amount does not accrue to the Benefit Period Deductible Amount and must be paid in addition to the Benefit Period Deductible Amount and the Family Deductible Amount.
2. The Inpatient Hospital Deductible Amount does not apply to satisfaction of the Out-of-Pocket Amount.

D. Prescription Drug Deductible Amount

The dollar amount, if shown in the Schedule of Benefits, which each Member 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 – A person, other than the Subscriber, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

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

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

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

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

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

Eligible Person - A person entitled to apply to be a Subscriber 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 – Any health care service provided to evaluate and/or treat an Emergency Medical Condition requiring immediate unscheduled medical care.

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.

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 Members 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 We identify as a Generic Drug. Classification of a Prescription Drug as a Generic Drug is determined by Us and not by the manufacturer or pharmacy. We classify 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 Us.

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

Group – Any company, partnership, association, corporation or other legal entity which has made application for coverage herein and has agreed to comply with all the terms and requirements of this Benefit Plan. For purposes of this Benefit Plan, the Group is the policyholder.

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 Company. 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 (R.N.) 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 Members 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 Company.

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 Company 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 Member 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 Member as an Outpatient, the Member does not meet the criteria for an Inpatient.

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

Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination We make 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 program (TEC) or other non-affiliated technology evaluation center(s);
 2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or

3. reference to federal regulations.

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) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

Member – A Subscriber or an enrolled Dependent.

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 (formerly 22:669) (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 Company. The definition of Mental Disorder shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

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

Newly Born Infant – Infants 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.

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

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

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

Out-of-Pocket 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 Member for Covered Services in one (1) Benefit Period.

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

Partial Hospitalization Programs - These programs are defined as structured and medically supervised day, evening and/or night treatment programs. Program services are provided to patients at least four (4) hours/day and are available at least three (3) days/week, although some patients may need to attend less often. The services are of essentially the same nature and intensity (including medical and nursing) as would be provided in a hospital except that the patient is in the program less than twenty-four (24) hours/day. The patient is not considered a resident at the program. The range of services offered is designed to address a mental health and/or substance-related disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

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

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

Prescription Drug Formulary – A list of specific Prescription Drugs that are covered under this insurance policy.

Preventive or Wellness Care – Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage.

Private Duty Nursing Services – Services of an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) 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 R.N. or L.P.N.

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

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 Us. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members 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 Us or another Blue Cross and Blue Shield plan to participate in a PPO Network. We call these Providers "PPO Providers," "Preferred Providers," or "Network Providers."
- B. Participating Provider – A Provider that has a signed contract with Us or another Blue Cross and Blue Shield plan for other than a Preferred Care or PPO Network.
- C. Non-Participating Provider – A Provider that does not have a signed contract with Us or another Blue Cross and Blue Shield 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.

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 Company 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 Benefit 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.

Subscriber – An employee, retiree, or elected official who has satisfied the specifications of this Benefit Plan's Schedule of Eligibility and has enrolled for coverage, and to whom the Company has issued a copy of the Benefit Plan.

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.
- E. Other procedures as defined and approved by the Company.

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

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

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

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

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

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

A. Eligibility

1. Subscriber. To be eligible to enroll as a Subscriber, an individual must be:
 - a. an employee who has satisfied any criteria designated by Us, has satisfied any Eligibility Waiting Period required by the Group, and who is working the number of hours designated by the Company in the Application for Group Coverage.
 - b. a retiree who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Benefits.
 - c. an elected official who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Benefits.
2. Dependent. To be eligible to enroll as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Company that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Benefit Plan.
 - a. SPOUSE: The Subscriber's legal spouse.
 - b. CHILDREN: A child under age twenty-six (26) who is one of the following:
 - (1) born of the Subscriber; or
 - (2) legally placed for adoption with the Subscriber; or
 - (3) legally adopted by the Subscriber; or
 - (4) a child for whom the Subscriber or his legal spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Subscriber or his legal spouse is a court appointed tutor/tutrix; or
 - (5) a child supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or
 - (6) a stepchild of the Subscriber; or
 - (7) a grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or
 - (8) the Subscriber's child, or grandchild in the legal custody of and residing with the Subscriber, who is incapable of self-sustaining employment by reason of being mentally or physically disabled prior to attaining age twenty-six (26). The Subscriber must furnish Company with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's 26th birthday. Company may require subsequent proof once a year after the initial two-year period following the child's 26th birthday.

B. Application for Coverage

1. Every Eligible Person may enroll for coverage under this Benefit Plan and may include any Eligible Dependents.

2. The Group will submit all enrollment information to Us as a prerequisite to coverage under this Benefit Plan.
3. No person will be covered under this Benefit Plan unless the Company has accepted the enrollment form or enrollment information in a format acceptable to Us and has issued an ID card or other written notice of acceptance. Payment of premiums to the Company for any person will not effectuate coverage unless and until Our ID card or other written acceptance has been issued, and in the absence of such issuance, the Company's liability will be limited to refund of the of premiums paid.
4. This Group Benefit Plan and coverage under it will not be issued or renewed unless the percentage of Eligible Persons specified in the Application for Group Coverage is enrolled.

C. Available Classes of Coverage

The classes of coverage defined below are available subject to the selection of class or classes of coverage by the Group as shown on the Application for Group Coverage. The Group has the right to change the classes of coverage selected when needed by sending a request to change classes to Our Underwriting Department.

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

D. Effective Date

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

1. If a person is an Eligible Person on this Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, this Group's Benefit Plan Date will be the Effective Date of coverage.
2. If a person becomes an Eligible Person after this Group's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s) on or before the eligibility date and the enrollment form is received by the Company within thirty (30) days of the eligibility date, the Effective Date of coverage will be the eligibility date.
3. If an Eligible Person's application for coverage for self or for self and any eligible Dependent(s) is not received by Us within thirty (30) days of the eligibility date or Special Enrollment Period as described below, the request for enrollment will be denied. The Eligible Person shall be eligible to enroll for coverage during the next Open Enrollment Period.
4. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), and the enrollment form is received by the Company within one hundred and eighty (180) days of the date of birth, the Effective Date of coverage will be the date of birth.

E. Court Ordered Determination

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

F. Special Enrollment

1. Special Enrollment Due to Loss of Certain Other Coverage

Special Enrollment Rights due to loss of certain other coverage are available only to current employees or elected officials and their Dependents. These rights are not available to retirees.

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

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

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

A Special Enrollee under this section must request enrollment for coverage under this Benefit Plan within thirty (30) days after other coverage ends (or after the employer stops contributing toward the other non-COBRA coverage). If such enrollment is received by a Blue Cross and Blue Shield of Louisiana office within thirty (30) days after loss of other coverage, coverage will become effective on the date other coverage is

lost. If the enrollment is not received within thirty (30) days of the loss of other coverage, but is received within sixty (60) days of loss of other coverage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if Blue Cross and Blue Shield of Louisiana does not receive the request for enrollment form within sixty (60) days of the loss of other coverage.

2. Special Enrollment of a Dependent Child Due to Loss of Coverage Under the Children's Health Insurance Program or a Medicaid Program
 - a. This Benefit Plan provides a Special Enrollment Period for an employee or family Dependent(s) if either (1) are covered under Medicaid or State Children's Health Insurance Program ("CHIP"), and lose that coverage because of loss of eligibility; or (2) they become eligible for premium assistance under the CHIP program. To qualify, employee must request coverage in this Group health plan no later than sixty (60) days after either the date of coverage termination under Medicaid or CHIP or the date employee or Dependent is determined to be eligible for such premium assistance. Request for special enrollment under this section must be received by a Blue Cross and Blue Shield of Louisiana office within the sixty (60) day period following loss of coverage or the date employee or Dependent is determined to be eligible for premium assistance. When special enrollment under this section is made timely and received by Company timely, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP or the date employee or Dependent is eligible for premium assistance.
 - b. Employee may disenroll a child Dependent from this coverage and enroll the child in CHIP coverage effective on the first day of any month for which the child is eligible for such CHIP coverage. Employee must promptly notify Company in writing of the child's disenrollment to avoid continued coverage under this Plan.
3. Special Enrollment Due to Acquiring a Dependent
 - a. This Benefit Plan shall provide for a special enrollment period during which the Dependent of a participating employee, retiree, or elected official may be enrolled on the plan. If not already participating, a current employee or elected official may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period. (Retirees who are not currently participating do not have these special enrollment rights for adding Dependents and may not come on the plan for this reason.)
 - b. A person becomes a Dependent of the covered or eligible employee, retiree or elected official through marriage, birth, adoption, or placement for adoption. In the case of the birth, adoption, or placement for adoption of a child, the spouse of the employee, retiree or elected official may be enrolled as a Dependent if he is otherwise eligible for coverage.
 - c. If the Group offers multiple health plan options, another option may be chosen by the current employee, retiree or elected official for himself and Dependents when special enrollee status applies.
 - d. There may be a one month period of automatic coverage for Newly-Born Infants (natural born or adopted), as described below. Any period of automatic coverage runs concurrently with the Special Enrollment Period for adding these infants to this Benefit Plan.
 - e. The Special Enrollment Period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied and any period of automatic coverage will end.
 - f. In the case of a birth, adoption, or placement for adoption, a current employee may enroll himself, his spouse and/or the newborn/adopted child and other eligible dependent children. The enrollment must be requested by signing an enrollment form no later than thirty (30) days after the birth, adoption, or placement for adoption.

If the enrollment form is received by a Blue Cross and Blue Shield of Louisiana office no later than thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth for a natural Newly Born Infant, and upon the date of adoption, or placement for adoption for an adopted Newly Born Infant. A Subscriber may enroll an unborn natural child prior to birth, however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth.

If the signed enrollment form is not received by Us within thirty (30) days of birth, adoption or placement for adoption, any automatic coverage period will end. If the signed enrollment form is not received by Us within thirty (30) days of birth, adoption or placement for adoption but is received within sixty (60) days of birth, adoption or placement for adoption, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. No coverage will be available if the enrollment form is not signed within thirty (30) days of the birth, adoption, or placement of adoption. Coverage will not be available if We do not receive the enrollment form within sixty (60) days of birth, adoption, or placement for adoption.

- g. In the case of marriage, a current employee may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested by signing an enrollment form within thirty (30) days of the marriage. Coverage will become effective on the date of marriage if the enrollment form is received by a Blue Cross and Blue Shield of Louisiana office within thirty (30) days of the marriage. If the enrollment form is not received by Us within thirty (30) days of marriage, but is received within sixty (60) days of marriage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment.

Coverage will not be available if the enrollment form is not signed within thirty (30) days of the marriage. Coverage will not be available if We do not receive the enrollment form within sixty (60) days of marriage.

4. Automatic Coverage Period for Newly Born Infants (Newborns)

- a. If a child is born to a Subscriber holding Subscriber Only coverage or Subscriber and Spouse coverage, the following will apply:
 - (1) Such child will be covered automatically for one month from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to his home, whichever is longer. This is the automatic coverage period. Automatic coverage for the child will be provided on the mother's policy, if any. If the mother has no policy, then automatic coverage will be provided on the father's policy, provided he has notified Us of the birth of the child. Coverage for the child will continue in effect thereafter, only upon Our receipt of a completed Change of Status Card prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the child are paid when billed.
 - (2) If the completed Change of Status Card is not received within this one month period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the child must be made at open enrollment or under a special enrollment provision.
- b. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), the Effective Date for coverage for such child will be the date of birth. You must notify Us within one hundred and eighty (180) days of the birth to update Our records.

5. Automatic Coverage Period for Newly Born Adopted Infants

a. For Members holding Subscriber Only coverage or Subscriber and Spouse coverage:

If within one month of the birth of a child, the child is either: legally placed into Subscriber's home for adoption following a voluntary act of surrender to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to a Subscriber, the following will apply:

- (1) The child will be covered automatically for one month from the date of legal placement into the Subscriber's home or from the custody order, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit, whichever is longer. The infant will not be covered from birth. Coverage for the infant will continue in effect thereafter, only upon Our receipt of a completed Change of Status card prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the infant are paid when billed.
- (2) If the completed Change of Status Card is not received within this one month period of automatic coverage, coverage for the infant will terminate upon the expiration of the period of automatic coverage. Any later request to add coverage for the child may be made at open enrollment or under a special enrollment provision.

b. For Members holding Subscriber and Family coverage or Subscriber and Child(ren) coverage:

If within thirty (30) days of the birth of a child, the Newly Born Infant is either: legally placed into the Subscriber's home for adoption following a voluntary act of surrender, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to a Subscriber holding coverage which includes Dependent children, the Effective Date of coverage of the adopted Newly Born Infant will be the date of placement into Subscriber's home or the date of the custody order. The child will not be effective from birth. You must notify Us within one hundred eighty (180) days of the date of placement in the home or of the custody order to update Our records.

6. In all special enrollee circumstances, an employee, retiree or elected official must be enrolled in this Benefit Plan in order for his Dependent(s) to be enrolled.

ARTICLE IV.

BENEFITS

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

A. 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 Company will provide Benefits in accordance with the Coinsurance percentage shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Member during a Benefit Period. The following Deductibles may apply to Covered Benefits provided by this Benefit Plan. Deductibles do not accrue to the Out-of-Pocket Amount.
 - a. Benefit Period Deductible Amount: The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that You must pay within a Benefit Period before this Contract 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: For Members in a class of coverage with more than one Member, this aggregate amount shown in the Schedule of Benefits is the maximum deductible amount that a family must pay before this Contract starts paying Benefits. Once a family has met its Family Deductible Amount, this

Contract starts paying Benefits for all Members of the family, regardless of whether each family Member has met his individual Benefit Period Deductible. No family Member may contribute more than the Benefit Period Deductible Amount to satisfy the aggregate amount required of a family. Family Deductibles may apply to other types of Deductibles described in this Contract. Only Benefit Period Deductible Amounts accrue to the Family Deductible Amount.

- c. Inpatient Hospital Deductible Amount: The dollar amount, if shown in the Schedule of Benefits, of Hospital charges which the Member must pay for each covered Admission. This Inpatient Hospital Deductible Amount may be waived for certain Hospitals, if shown in the Schedule of Benefits. The Inpatient Hospital Deductible Amount does not accrue to the Benefit Period Deductible Amount and must be paid in addition to the Benefit Period Deductible Amount and the Family Deductible Amount.
 - d. Prescription Drug Deductible Amount: The dollar amount, if shown in the Schedule of Benefits, which each Member 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.
2. The Allowable Charges incurred for Covered Services during the months of October, November and December, which were applied toward the Benefit Period Deductible Amount for that Benefit Period, but did not satisfy the Benefit Period Deductible Amount, will be applied to the Benefit Period Deductible Amount for the next calendar year. If the Deductible Amount is met or exceeded, this Deductible carryover feature is not available. This carryover feature applies to the Benefit Period Deductible Amount only. It does not apply to the Prescription Drug Deductible Amount, Family Deductible Amount, or any other type of Deductible described in this Benefit Plan.
 3. We will apply the Member'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 Member, then when the Member receives Covered Services from another Provider, that Provider also collects the Member's Deductible Amount. This generally occurs when the Member's Claims have not been received and processed by Us. Our system will only show the Deductible Amount applied for Claims that have been processed.

Therefore, the Member 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 Member overpays his Deductible Amount, the Member is entitled to receive a refund from the Provider in which the overpayment was made.

4. Under certain circumstances, if Company pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, Company may collect such amounts directly from You. You agree that Company has the right to collect such amounts from You.

B. Physician Office Copayment Services (if shown as available in the Schedule of Benefits)

1. Copayment services - The Physician Office Copayment means the following Outpatient services when rendered in a Physician's, Optometrist's, podiatrist's, chiropractor's or nurse Practitioner's office or clinic, or when rendered in a Retail Health Clinic, Urgent Care Center or federally qualified rural health clinic:
 - a. office visit charges and Consultation;
 - b. injections, allergy serums, and vials of allergy medications;
 - c. surgical procedures performed in the office;
 - d. radiation treatments obtained in Physician's office;
 - e. office visit charges and consultations for Mental Health; and/or
 - f. office visit charges and consultations for substance abuse.

2. Copayment services do not include the following services and/or supplies. The following services and/or supplies are subject to the Benefit Period Deductible Amount and applicable Coinsurance percentage shown in the Schedule of Benefits:
 - a. allergy testing;
 - b. Physical Therapy, Occupational Therapy, and Speech Therapy;
 - c. Prescription Drugs;
 - d. Preventive or Wellness Care; and/or
 - e. medical and surgical supplies.
 - f. high tech imaging, including but not limited to MRIs, MRAs, CT scans, PET scans and nuclear cardiology.

C. Out-of-Pocket Amount

1. After the Member has met the Out-of- Pocket Amount, as shown in the Schedule of Benefits, We will pay one hundred percent (100%) of the Member's Coinsurance amount which is based on the Allowable Charge.
2. The following accrue to the Out-of-Pocket Amount of this Benefit Plan:
 - a. Coinsurance
3. The following do not accrue to the Out-of-Pocket Amount of this Benefit Plan:
 - a. Copayment Amounts;
 - b. any charges in excess of the Allowable Charge;
 - c. any penalties the Member or Provider must pay; and
 - d. charges for non-Covered Services.
4. The following accrues to the Out-of-Pocket Amount of this Benefit Plan if shown in the Schedule of Benefits:
 - a. Deductible

D. Accumulator Transfers

Members' needs sometimes require that they transfer from one policy to another. Types of transfers include, but are not limited to, moving from one employer's plan to another, from a Group policy to an individual policy, an individual policy to a Group policy, or a Blue Cross and Blue Shield of Louisiana policy to an HMO Louisiana, Inc. policy. The type of transfer being made determines whether the Member's accumulators are carried from the old policy to the new policy. Accumulators include, but are not limited to, Deductibles, Out-of-Pocket Amounts, and Benefit Period Maximums.

ARTICLE V. HOSPITAL BENEFITS

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

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

The following services furnished to a Member by a Hospital are covered:

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Member requiring an intensive level of care.
3. In a 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 Members with Mental Health, substance abuse Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

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

C. Pre-Admission

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

ARTICLE VI.

MEDICAL AND SURGICAL BENEFITS

Benefits for the following medical and surgical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. A Member 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 Company 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 the Company.

(2) The Allowable Charge includes the rebundled procedure. The Company will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as determined by the Company.

e. Mutually Exclusive Procedure(s)

(1) Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made.

(2) The Allowable Charge includes all procedures performed at the same surgical setting. Procedure(s), which are not considered Medically Necessary, will not be covered.

3. Assistant Surgeon

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

4. Anesthesia

- a. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by Us. 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 We determine 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

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

- A. Coverage is available for Prescription Drugs if shown as covered in the Schedule of Benefits. The Prescription Drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that We determine and only those Prescription Drugs that We determine are Medically Necessary will be covered. Certain Prescription Drugs may be subject to Step Therapy or require prior Authorization as shown in the Schedule of Benefits.

- B. Prescription Drugs dispensed at retail or through the mail are subject to the Prescription Drug Copayment or Coinsurance Amount and any applicable Prescription Drug Deductible Amount shown in the Schedule of Benefits. The Member may be required to pay a different Copayment or Coinsurance for the different drug tiers. Prescription Drugs may be subject to quantity limitations.
- C. If a Prescription Drug Deductible Amount is applicable, this amount must be satisfied prior to any applicable Prescription Drug Copayment or Coinsurance. The Prescription Drug Deductible Amount is separate from the Benefit Period Deductible Amount and does not accrue to the satisfaction of the Out-of-Pocket Amount.
- D. Prescription Drug Copayments and Coinsurance are based on the following tier classifications shown in the Schedule of Benefits. Tier placement is based on Our evaluation of a particular medication's clinical efficiency, safety, cost, and pharmaco-economic factors.
 - 1. Tier 1 - A Prescription Drug that is a Generic or a low cost Brand-Name Drug.
 - 2. Tier 2 - A Prescription Drug that is a Brand-Name Drug.
 - 3. Tier 3 - A Prescription Drug that is a Brand-Name Drug or a Generic Drug that may have a therapeutic alternative as a Tier 1 or Tier 2 drug. Covered compounded drugs are included in this Tier.
 - 4. Tier 4 - A Prescription Drug that is a Multi-Source Brand Drug.
 - 5. Tier 5 - Injectable Prescription Drugs include those medications that are intended to be self-administered. However, insulin and injectable antihemophilic Prescription Drugs may be included in another drug tier.
- E. Necessary insulin syringes and test strips are covered under the Prescription Drug Benefit.
- F. The Member can view Our Blue Selections Rx Member Guide on Our website at www.bcbsla.com or request a copy by mail by calling Our pharmacy benefit manager at the telephone number indicated on the Member's ID card.
- G. Drug Utilization Management Program

Our Drug Utilization Management Program features a set of closely aligned programs that are designed to promote Member safety, appropriate and cost effective use of medications, and monitor health care quality. Examples of these programs include:

- 1. Prior Authorization – As part of Our Drug Utilization Management program, Members and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on Our website at www.bcbsla.com or by calling the customer-service telephone number on the Member's ID card. If the Prescription Drug requires prior Authorization, the Member's Physician must call the medical Authorization telephone number on the Member's ID card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.
- 2. Safety checks – Before the Member's prescription is filled, Our pharmacy Benefit manager or We perform quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g. refill prior to seventy-five percent (75%) day supply used).
- 3. Quantity Per Dispensing Limits/Allowances – Prescription Drugs selected by Us are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity Per Dispensing Limits/Allowances are based on the following: (a) the manufacturer's recommended dosage and duration of therapy; (b) common usage for episodic or intermittent treatment; (c) FDA-approved recommendations and/or clinical studies; or (d) as determined by Us.

4. Step Therapy – In some cases, We may require the Member to try one Prescription Drug to treat a medical condition before We will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, We may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then We will cover a prescription written for Drug B. However, if Your Physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B Brand-Name drug included in the Step Therapy program without first trying a Step A generic alternative, You will be responsible for the full cost of the drug.
- H. Some pharmacies have contracted with Us or with Our pharmacy benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base Our payment for the Member's Covered Prescription Drugs.
- I. When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our pharmacy Benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that it dispenses, the Allowable Charge is the negotiated amount that Participating Pharmacies have agreed to accept for drugs dispensed.
- J. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Member should submit Claims on Our Prescription Drug claim form.

For information on how to file Claims for foreign Prescription Drug purchases, the Member should contact Us or Our pharmacy benefit manager at the telephone number indicated on the Member's ID card.

- K. As part of Our administration of Prescription Drug Benefits, We may disclose information about the Member's Prescription Drug utilization, including the names of the Member's prescribing Physicians, to any treating Physicians or dispensing pharmacies.
- L. Any savings or rebates We receive on the cost of drugs purchased under this Benefit Plan from drug manufacturers are used to stabilize rates.
- M. Specialty Pharmacy Program

The Specialty Pharmacy Program covers certain drugs commonly referred to as high-cost Specialty Drugs. We contract with Specialty Pharmacies to provide additional helpful services, such as courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the Specialty Drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis. Specialty Pharmacies specialize in dispensing and delivering drugs that require special handling. These Pharmacies comprise the "Specialty Pharmacy Network." The Member may contact Our Customer Service Department, or access www.bcbsla.com/pharmacy, to identify the drugs contained on the Specialty Drug list. Members may also access the website or contact Our Customer Service Department for assistance in locating the Network specialty pharmacy that can be used to obtain medication.

N. Prescription Drug Formulary

This insurance policy covers Prescription Drugs and uses an open Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this insurance policy. With an open formulary, Company automatically includes new Prescription Drugs to Your coverage when drug manufacturers release these new drugs for sale. Placement of Prescription Drugs on a drug tier may be based on a drug's quality, safety, clinical efficacy, available alternatives, and cost. Company reviews the Prescription Drug Formulary at least once per year.

Information about Your formulary is available to You in several ways. Most Members receive information from Us in the mail about their Prescription Drug coverage, including information about specific drugs, cost, and drug lists. We also have information available for You to print and discuss with Your doctor. You can review and print formulary information immediately from Our website, www.bcbsla.com.

Notice: You may also contact Us at the telephone number on Your ID card to ask whether a specific drug is included in Your formulary. If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your Physician or other authorized prescriber will prescribe the drug for a particular medical condition or mental illness. You may file a written Appeal to Us if a Prescription Drug is not included in the formulary and Your Physician or authorized prescriber has determined that the drug is Medically Necessary for You. Instructions for filing an Appeal are included in this policy.

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to a Member. The Member must pay all Copayments (if applicable) and Coinsurance percentages shown in the Schedule of Benefits. The Deductible Amount does not apply to covered Preventive or Wellness Care, unless otherwise stated. Preventive or Wellness Care services may be subject to other limitations shown in the Schedule of Benefits.

If a Member receives Covered Services from a Preferred Care Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge. When Preventive or Wellness Care services are rendered by any Provider who is not a Preferred Care Provider, Benefits will be subject to the Coinsurance percentage shown in the Schedule of Benefits.

A. Well Woman Examinations

1. Two (2) routine annual visits per Benefit Period to an obstetrician/gynecologist, provided that the second visit shall be permitted based upon Medical Necessity only. Follow-up treatments may be made within sixty (60) days following either visit if related to a condition diagnosed or treated during the gynecological exam. Only the first routine annual visit shall be considered Preventive or Wellness Care. The Deductible Amount, Copayment or Coinsurance percentage, if shown in the Schedule of Benefits, applies to all but the first visit.
2. One (1) routine Pap smear per Benefit Period.
3. One (1) mammography examination 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.

B. Physical Examinations

1. One (1) routine wellness physical examination per Benefit Period. Certain routine wellness diagnostic tests ordered by Your Physician are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Care Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels. Higher tech services such as an MRI, MRA, CT scan, PET scan, nuclear cardiology, colonoscopy, flexible sigmoidoscopy and endoscopy are not covered under this Preventive or Wellness Care Benefit. These higher tech services may be covered under standard contract Benefits when the tests are Medically Necessary.
2. Well Baby Care.

C. Immunizations

1. 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).
2. Immunizations recommended by the Member's Physician.

D. Other Wellness Services

1. One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, is covered for Members fifty (50) years of age or older, and as recommended by his Physician if the Member is over forty (40) years of age.

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

2. Hemocult (colon) test, limited to one per Benefit Period.

WHAT A MEMBER PAYS FOR PREVENTIVE OR WELLNESS CARE BENEFITS		
WELLNESS BENEFIT	PREFERRED CARE NETWORK	ALL OTHER PROVIDERS
Well Woman Exams		
OB/GYN office visits	No Cost	Coinsurance
Routine Pap Smear	No Cost	Coinsurance
Mammogram	No Cost	Coinsurance
Physical Exams		
Routine Physical Exam (including related diagnostic tests)	No Cost	Coinsurance
Well Baby Care	No Cost	Coinsurance
Immunizations		
State-Mandated Immunizations	No Cost	Coinsurance
All Other Recommended by Physician	No Cost	Coinsurance
Other Wellness Services		
PSA Test	No Cost	Coinsurance
Hemocult (colon) test	No Cost	Coinsurance

ARTICLE IX. MENTAL HEALTH BENEFITS

- A. Treatment of Mental Health is covered. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treatment of Mental Health do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
- B. Inpatient treatment for Mental Health must be Authorized as provided in the Care Management Article of this Benefit Plan.

ARTICLE X. SUBSTANCE ABUSE BENEFITS

- A. Benefits for treatment of Substance Abuse are available. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.
- B. Inpatient treatment for substance abuse must be Authorized as provided in the Care Management Article of this Benefit Plan, when coverage for alcohol and/or drug 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 PPO 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 Member's ID card for a copy of the directory.

- A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- B. Extraction of impacted teeth.
- C. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.)
- D. Excision of exostoses or tori of the jaws and hard palate.
- E. Incision and drainage of abscess and treatment of cellulitis.
- F. Incision of accessory sinuses, salivary glands, and salivary ducts.
- G. Anesthesia for the above services or procedures when rendered by an oral surgeon.
- H. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia Benefits are not available for treatment rendered for Temporomandibular Joint (TMJ) Disorders.
- J. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To determine if the Member is eligible for these Benefits, please call Our Customer Service Unit at the phone number on the Member's ID card, and ask to speak to a Case Manager.

ARTICLE XII.

ORGAN, TISSUE, AND BONE MARROW TRANSPLANT BENEFITS

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

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

If any organ, tissue or bone marrow is sold rather than donated to a Member, 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 Provider facility, unless otherwise approved by Us in writing. To locate an approved transplant facility, Members should contact Our Customer Service Department at the number listed on their ID card.
2. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

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

C. Solid Human Organ Transplants of the:

1. liver;
2. heart;
3. lung;
4. kidney;
5. pancreas;
6. small bowel; and
7. other solid organ transplant procedures which We determine 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), as specified below:

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 Article on Care Management.

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 We determine 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 We determine 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 Members under ARTICLE V and ARTICLE VI of this Benefit Plan.

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

This policy covers Pregnancy Care if Pregnancy Care is listed as a covered Benefit on the Schedule of Benefits. Even if You do not have Pregnancy Care Benefits, We have several maternity programs available to help pregnant Members deliver healthy babies. Please call Our Customer Service Department at the number on the back of Your ID card when You learn You are having a baby. When You call, We'll let You know what programs are available to You.

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 Benefits are provided as follows:

1. Medical and surgical Services.
 - a. Initial office visit and visits during the term of the pregnancy.
 - b. Diagnostic Services.
 - c. Delivery, including necessary pre-natal and post-natal care.
 - d. Medically Necessary abortions required 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. For a Newborn Who is Covered at Birth as a Dependent

1. Medical and surgical services rendered by a Physician, for treatment of illness, pre-maturity, post-maturity, or congenital condition of a newborn and circumcision. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.
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 48 hours following a vaginal delivery, or less than 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 48-hour or 96-hour 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 48 hours or 96 hours. However, to use certain providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain precertification. For information on precertification, contact Your Plan 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 Member 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 must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.
3. 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. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.
3. 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 Member's plan of care.

- b. As part of a Home Health Care agency pursuant to the Member's plan of care.
- c. To a patient in a nursing home pursuant to the Member's plan of care.
- d. Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness.
- e. To an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the 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. The therapy must be used to improve or restore speech language deficits or swallowing deficits.
- 3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to the receipt of services.

D. Chiropractic Services

- 1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.
- 2. 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 MEMBER, SUBJECT TO OTHER LIMITATIONS SHOWN IN THE SCHEDULE OF BENEFITS.

A. Accidental Injury Benefits (if shown in the Schedule of Benefits)

- 1. If a Member incurs medical expenses for treatment or services as a direct result of a traumatic bodily injury sustained solely by accidental means, We agree to pay one hundred percent (100%) of the Allowable Charge for such medical expenses actually incurred up to the maximum amount per Benefit Period shown in the Schedule of Benefits for this Accidental Injury Benefit. Once the maximum is exhausted, the Benefit Period Deductible Amount will apply and regular Benefits will be provided to the Member.
- 2. No Benefits shall be provided under this Accidental Injury Benefits section for services or supplies rendered in connection with services or supplies provided under other Benefit sections of this Benefit Plan.

B. Ambulance Service Benefits

- 1. Benefits are available for Ambulance Services for local transportation for Emergency Medical Conditions or Medically Necessary Inpatient Hospital services only as follows:
 - for the Members, to or from the nearest Hospital that can provide services appropriate to the Member's condition for an illness or injury requiring Hospital care;
 - for the Newly Born Infant, to the nearest Hospital or neonatal special care unit for treatment of illnesses, injuries, congenital birth defects and complications of premature birth which require that level of care;

- for the Temporarily Medically Disabled Mother of the ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.
2. Benefits for Air Ambulance services are available in for Emergency Medical Conditions or when the Member is in a location that cannot be reached by ground ambulance. The Air Ambulance service must be specifically requested by police or medical authorities present at the site with the Member in order for Air Ambulance to be covered.
 3. In a non-emergency situation, air Ambulance Service is not covered unless the Member requests and receives Authorization from the Company prior to the service being rendered.
 4. Transport of ambulatory or non-ambulatory individuals for services that can be scheduled in advance (e.g., dialysis) is not a covered Ambulance Service. Transport by wheelchair van is not a covered Ambulance Service.
 5. Ambulance Service Benefits will be provided as follows:
 - a. If a Member pays a periodic fee to an ambulance membership organization with which the Company does not have a Provider Agreement, Benefits for expenses incurred by the Member for its Ambulance Services will be based on any obligation the Member must pay that is not covered by the fee. If there is in effect a Provider Agreement between the Company and the ambulance organization, Benefits will be based on the Allowable Charge.
 - b. No Benefits are available if transportation is provided for a Member's comfort or convenience, or when a Hospital transports Members between parts of its own campus.

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. Members who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis, when the Company determines it is Medically Necessary. Applied Behavior Analysis is not covered for Members age twenty-one (21) and older.

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

F. Breast Reconstructive Surgery Services

1. A Member 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 Member 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.

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

H. Clinical Trial Participation

1. This Benefit Plan shall provide coverage 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 I, Phase 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.

I. Colorectal Cancer Screening Benefits

Benefits are available for routine colorectal cancer screenings. Routine colorectal cancer screening shall mean a fecal occult blood test, flexible sigmoidoscopy, or colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational.

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 programs for diabetes self-management is covered subject to the following:
 - a. The program must be determined to be Medically Necessary by a Physician and provided by a licensed health care professional who certifies that the Member has successfully completed the training program.
 - b. The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

K. Dietician Visits

Benefits are available for visits to registered dietitians. Diabetics that need the services of a Dietician should receive those services as part of their Benefits for Diabetes Education and Training for Self-Management.

L. Disposable Medical Equipment or Supplies

Disposable medical equipment or supplies related to and necessary for the administration of Prescription Drugs, such as syringes and needles, and other disposable medical equipment or supplies which have a primary medical purpose are covered and will be subject to reasonable quantity limits as determined by Us. Benefits for these supplies will be determined by applying the same Coinsurance percentage applicable to Durable Medical Equipment, to the Allowable Charges for these supplies.

M. 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 Member 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 Company'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 Member 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.

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 Us.

2. Orthotic Devices

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

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.
- b. Repair or replacement of the Orthotic Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. We will determine this time period.
- c. Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when a Member 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 is Authorize by the Company 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 Company will determine this time period.
- c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Member 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 We Authorize, and are covered subject to the following:

- a. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time period.
- b. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Member selects a deluxe appliance solely for his comfort or convenience. A Member may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Benefit Plan and may pay the difference between the price of the device and the Benefit payable, without financial or contractual penalty to the provider of the device. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.
- c. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

N. Hearing Aid Benefits

Benefits are available for hearing aids for covered Members age seventeen (17) and under when obtained from a Network Provider or another Provider approved by Us. 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.

We will pay up to Our Allowable Charge for this Benefit. We may increase Our Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge. This Benefit is not subject to Coinsurance or Deductibles.

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

O. 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 Member in lieu of an Inpatient Hospital Admission are covered, and may be limited if shown in the Schedule of Benefits.

P. Interpreter Expenses for the Hearing Impaired

Services of a qualified interpreter/transliterater are covered when the Member needs such services in connection with medical treatment or diagnostic consultations if the services are required because of a Member's hearing impairment or a language communication failure. These services are not covered if the services are rendered by a family member, or if the medical treatment or consultation is not covered.

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

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

Benefits for Low Protein Food Products are limited to the treatment of the following diseases:

Phenylketonuria (PKU)
Maple Syrup Urine Disease (MSUD)
Methylmalonic Acidemia (MMA)
Isovaleric Acidemia (IVA)
Propionic Acidemia
Glutaric Acidemia
Urea Cycle Defects
Tyrosinemia

R. Permanent Sterilization Procedures

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

S. Contraceptive Devices (Non-Permanent Sterilization)

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

T. Prescription Drugs

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

U. Private Duty Nursing Services

1. Coverage is available to a Member for Private Duty Nursing Services when performed on an Outpatient basis and when the nurse is not related to the Member by blood, marriage or adoption.
2. Private Duty Nursing Services are covered at the Coinsurance level.
3. Inpatient Private Duty Nursing Services are not covered.

V. 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.

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

The following applies when the Physician Office Visit Copayment Benefit is purchased. The Member will pay the Physician Office Visit Copayment only when he visits a Network physician or other Provider listed in the Copayment Services section. Medically necessary X-rays, lab tests, and machine tests are covered at 100% of the Allowable Charge, when performed within the office or clinic of a Network Provider that is subject to the Physician Office Visit Copayment. Lab tests are also covered at 100% of the Allowable Charge when performed by an independent laboratory (that is contracted with Us to be in Our PPO Network). X-rays, lab tests, and machine tests taken, performed or processed in an Outpatient Facility or other setting are subject to Deductible and Coinsurance. Lab tests that are taken, performed, or processed by a Non-Network Provider are subject to Deductible and Coinsurance. High tech imaging, including but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology, are always subject to Deductible and Coinsurance, even if taken in the office or clinic of a Network Provider and the Physician Office Visit Copayment Benefit is purchased.

The following applies when the Physician Office Visit Copayment Benefit is not purchased. 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 Services and Supplies, Selection of Provider, Penalties and Penalty for Using a Non-Network Provider

1. Authorization and Selection of Provider and Penalty for Failure to Authorize

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

If a Member wants to receive services from a Non-Network Provider and obtain the highest level of Benefits, he must notify Our Care Management Department before services are rendered. We will approve the use of a Non-Network Provider only if We determine that the services **cannot** be provided by a Network Provider within a seventy-five (75) mile radius of the Member's home. We must approve the use of the Non-Network Provider and issue any required Authorization before services are rendered. If We do not approve use of the Non-Network Provider and issue an Authorization prior to services being rendered, Covered Services that are later determined to be Medically Necessary will be paid at the lower Non-Participating Provider level shown on the Schedule of Benefits. A penalty of thirty percent (30%) of the Allowable Charge may be applied when the Provider is a Non-Participating Hospital.

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

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

If Authorization is not requested prior to the Admission, We will have the right to determine if the Admission was Medically Necessary. If the Admission was not Medically Necessary, the Admission will not be covered and the Member must pay all charges incurred for Hospital services during the Admission. If the Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the service.

If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown under the Authorization of Services, Equipment and Supplies section in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization. The Network Provider is responsible for all charges not covered. The Member remains responsible for his Copayment, Deductible and applicable Coinsurance percentage.

2. Authorization of Admissions

a. Authorization of Elective Admissions

- (1) The Member is responsible for ensuring that his Provider notifies Our Care Management Department of any Elective or non-emergency Inpatient Hospital Admission. The Company must be notified (by calling the telephone number shown in the Schedule of Benefits or the Member'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 Company when the Hospital Inpatient setting is documented to be Medically Necessary.
- (2) If a request for Authorization is denied by Us for an Admission to any facility, the Admission is not covered and the Member must pay all charges incurred during the Admission for which Authorization was denied.

- (3) If Authorization is not requested prior to an Admission, We will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.
 - (a) If a Network Provider fails to obtain a required Authorization for the Admission, We will reduce Allowable Charges by the amount shown under the Authorization of Inpatient and Emergency Admissions section in the Schedule of Benefits. The Network Provider is responsible for all charges not covered. The Member remains responsible for his Copayment, Deductible and applicable Coinsurance percentage. If an Admission was not Medically Necessary, the Admission is not covered.
 - (b) If Authorization is not requested prior to the services being rendered by a Non-Network Provider, in addition to any Deductible and Coinsurance amount required in this Benefit Plan, the Member will be responsible for all charges 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.
 - (c) Additional amounts for which the Member is responsible because Authorization of an Elective or non-emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

- (1) It is the Member's responsibility to ensure that his Physician or Hospital, or a representative thereof, notifies the Company's Care Management Department of all Emergency Inpatient Hospital Admissions. Within forty-eight (48) hours of the Emergency Admission, the Company must be notified (by calling the telephone number shown in the Schedule of Benefits or the Member's ID card) regarding the nature and purpose of the Emergency Admission. The Company may waive or extend this time limitation if it determines that the Member is unable to timely notify or direct his representative to notify the Company of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend, the Company must be notified on its next working day. The appropriate length of stay for the Emergency Admission will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.
- (2) If Authorization is denied by Us for an Admission to any facility, the Admission will not be covered and the Member must pay all charges incurred during the Admission.
- (3) Additional amounts the Member must pay because Authorization of an Emergency Admission was denied or not requested are considered non-covered and will not apply toward the Out-of-Pocket Amount.

c. Concurrent Review

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

- (2) If We do not receive a request for Authorization for continued stay on or before the Member's last Authorized day, no days are approved past the last Authorized day, and no additional Benefits will be paid unless We receive and Authorize another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and We determine that it is not Medically Necessary for the Member to receive continued hospitalization or hospitalization at the level of care requested, We will notify the Member and his Providers, in writing, that the request is denied and no additional days are Authorized.
- (3) If We deny a Concurrent Review request or level of care request for Hospital Services, We will notify the Member, his Physician and the Hospital of the denial. If the Member elects to remain in the Hospital as an Inpatient thereafter, or at the same level of care, the Member 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.
- (4) Charges for non-authorized days in the Hospital that the Member must pay are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

3. Authorization - Other Covered Services and Supplies

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

If Authorization is not requested prior to a listed service being rendered or a listed supply being received, We will have the right to determine if the service or supply was Medically Necessary. If the service or supply was Medically Necessary, Benefits will be provided based on the participating status of the Provider of the service or supply.

- a. If a Network Provider fails to obtain a required Authorization, We will reduce the Allowable Charge by thirty percent (30%). This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Network Provider is responsible for all charges not covered. The Member remains responsible for his Copayment, Deductible and applicable Coinsurance percentage. If a service or supply was not Medically Necessary, the service or supply is not covered.
- b. If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Participating Provider level shown on the Schedule of Benefits. The Member is responsible for all charges not covered and remains responsible for his Copayment, Deductible and applicable Coinsurance percentage. If a service or supply was not Medically Necessary, the service or supply is not covered.

4. Appeals

- a. If either the Member or the Provider disagrees with the denial of any Authorization, the denial may be appealed as shown in the Complaints, Grievance and Appeals article of this Benefit Plan. The Member or the Provider may Appeal the denial by contacting the Company in writing within one hundred eighty (180) days of notice of the denial in accordance with the Complaints, Grievance and Appeals article of this Benefit Plan.
- b. If the Company does not reverse the decision, the Member 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 Member may qualify for Disease Management programs, at Our 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 Member, Physicians and caregivers may be included in all phases of the disease management program. The disease management nurse may also refer members to community resources for further support and management.
2. Disease Management Benefits - Blue Cross Blue Shield of Louisiana's Disease Management programs are committed to improving the quality of care for its Members as well as decreasing health care costs in populations with a chronic disease. The nurse works with Members 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 Member.

C. Case Management

1. The Member may qualify for Case Management Services, at Our discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.
2. The role of Case Management is to service the Member by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who Benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.
3. Our determination that a particular Member's medical condition renders the Member a suitable candidate for Case Management services will not obligate Us to make the same or similar determination for the Member or for any other Member: The provision of Case Management services to one Member will not entitle the Member or any other Member to Case Management services or be construed as a waiver of Our right to administer and enforce this Benefit Plan in accordance with its express terms.
4. Unless expressly agreed upon by the Us, 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 Member is receiving Case Management services.
5. The Member's Case Management services will be terminated upon any of the following occurrences:
 - a. We determine in Our sole discretion, that a Member 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 Member elects not to participate in the Case Management plan.

D. Alternative Benefits

1. The Member may qualify for Alternative Benefits, at the Company's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Member and to the Company.
2. The Company's determination that a particular Member's medical condition renders the Member a suitable candidate for Alternative Benefits will not obligate the Company to make the same or similar determination for any other Member; nor will the provision of Alternative Benefits to a Member entitle any other Member to Alternative Benefits or be construed as a waiver of the Company's right to administer and enforce this Benefit Plan in accordance with its express terms.

3. Unless expressly agreed upon by the Company, 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 Member is receiving Alternative Benefits.
4. Alternative Benefits provided under the Article are provided in lieu of the Benefits to which the Member is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Benefit Plan.
5. The Member's Alternative Benefits will be terminated upon any of the following occurrences:
 - a. We determine, in Our sole discretion, that the Member is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.
 - b. The Member 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 Us.

ARTICLE XVII. LIMITATIONS AND EXCLUSIONS

- A. Services, supplies and treatment for services that are not covered under this Benefit Plan and complications from services, supplies and treatment for services that are not covered under this Benefit Plan are excluded.
- B. Any of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown in the Schedule of Benefits. Unless otherwise shown as covered in the Schedule of Benefits, the following are not covered, **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**
 1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.
 2. Any charges exceeding the Allowable Charge.
 3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.
 4. Services, Surgery, supplies, treatment, or expenses:
 - a. other than those specifically listed as covered by this Benefit Plan. Benefits are not payable for services a Member has no obligation to pay, or for which no charge or a lesser charge would be made if a Member had no health insurance coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions;
 - b. rendered or furnished before the Member's Effective Date or after Member's coverage terminates, except as follows: Medical Benefits in connection with an Admission will be provided for an Admission in progress on the date a Member's coverage under this Benefit Plan ends, until the end of that Admission or until a Member has reached any Benefit limitations set in this Benefit Plan, whichever occurs first;
 - c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license.
 - d. to the extent payment has been made or is available under any other contract issued by Blue Cross and Blue Shield of Louisiana or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law, and except for limited Benefit policies;
 - e. paid or payable under Medicare Parts A or B when a Member has Medicare, except when Medicare Secondary Payer provisions apply;

- f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures for such determinations which are on file with the Louisiana Department of Insurance;
 - g. rendered as a result of occupational disease or injury compensable under any Workers' Compensation Law subject to the provisions of La. R.S. 23:1205(C). This exclusion shall not apply to services rendered to a Member holding ten (10%) percent or more ownership in the Group, if the Member has done all of the following: (1) legally opted to be excluded from workers' compensation coverage for the Group by entering into a written agreement with Group's worker's compensation carrier electing not to be covered by such coverage; (2) properly enrolled with Company in owner 24-hour health coverage; (3) furnished the Company with a copy of the written agreement between the Member and the worker's compensation carrier; (4) furnished the Company with written evidence of Member's ownership interest in Group. If this information is not submitted to Company at the time of Member's initial enrollment for health coverage, or upon acquisition of the required ownership percentage, then Member may enroll for this coverage at Member's next open enrollment opportunity;
 - h. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; or
 - i. rendered by a Provider who is the Member's spouse, child, stepchild, parent, stepparent or grandparent.
5. Services in the following categories:
- a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
 - b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;
 - c. those occurring as a result of taking part in a riot or acts of civil disobedience;
 - d. those occurring as a result of a Member's commission or attempted commission of a felony. This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Benefits are available to the Member for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or in case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition.
 - e. for treatment of any Member confined in a prison, jail, or other penal institution.
6. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**:
- a. rhinoplasty;
 - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
 - c. gynecomastia;
 - d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Benefit Plan;
 - e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants;
 - f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;

- g. diastasis recti;
 - h. biofeedback;
 - i. lifestyle/habit changing clinics and/or programs;
 - j. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies.
 - k. industrial testing or self-help programs (including, but not limited to, smoking cessation programs and supplies, and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations; and/or
 - l. recreational therapy;
 - m. primarily to enhance athletic abilities; and/or
 - n. Inpatient pain rehabilitation and pain control programs.
7. Services, Surgery, supplies, treatment, or expenses related to:
- a. routine eye exams, eyeglasses or contact lenses or exams (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered in the Schedule of Benefits;
 - b. eye exercises, visual training, or orthoptics;
 - c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;
 - d. hair pieces, wigs, hair growth, and/or hair implants;
 - e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or
 - f. visual therapy.
8. Services, Surgery, supplies, treatment or expenses related to:
- a. any costs of donating an organ or tissue for transplant when a Member is a donor except as provided in this Benefit Plan;
 - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;
 - c. the transplant of any non-human organ or tissue; or
 - d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.
9. Regardless of Medical Necessity, Benefits are not available for any of the following, except as specifically provided under this Benefit Plan:
- a. weight reduction programs;
 - b. removal of excess fat or skin, or services at a health spa or similar facility; or
 - c. obesity or morbid obesity.

10. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.
11. (Left blank intentionally).
12. Contraceptive devices that result in permanent sterilization.
13. Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits:
 - a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Xenical®), or medications used to enhance athletic performance;
 - b. any medication not proven effective in general medical practice;
 - c. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug;
 - d. fertility drugs;
 - e. minerals and vitamins, except for vitamins requiring a prescription for dispensation;
 - f. nutritional or dietary supplements, or herbal supplements and treatments;
 - g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available.
 - h. contraceptive drugs;
 - i. refills in excess of the number specified by the Physician or the dispensing limitation described in this Benefit Plan, or a refill prior to seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription;
 - j. any drugs used for smoking cessation except Zyban;
 - k. compounded drugs that exhibit any of the following characteristics: 1) are similar to a commercially available product; 2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval; 3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being administered topically); 4) compounded drugs that contain drug products or components of such drug products that have been withdrawn or removed from the market for reasons of safety; or 5) compounded prescriptions whose only ingredients do not require a prescription;
 - l. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;
 - m. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage;
 - n. Prescription Drugs related to a non-Covered Service;
 - o. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®);

- p. Medication, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner;
 - q. growth hormone therapy, except for chronic renal insufficiency, AIDS wasting, and Turners Syndrome, unless an endocrinologist confirms growth hormone deficiency with abnormal provocative stimulation testing; or
 - r. Prescription Drugs for and/or treatment of idiopathic short stature.
 - s. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Member misrepresentation to that prescriber. Limitation may include, but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy.
 - t. Prescription Drugs subject to the Step Therapy program when the Step Therapy program was not utilized or the drug was not approved by Company or its Pharmacy Benefit Manager.
14. Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider unless the provider is contracted with Our PBM.
 15. Covered drugs that typically require administration by a healthcare professional are covered under the medical Benefit when obtained from a healthcare professional. These drugs are not covered under the pharmacy Benefit when obtained from a pharmacy, unless provided in conjunction with Our Specialty Pharmacy Program and not otherwise excluded.
 16. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Member's Coinsurance and Our financial responsibility. We will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Member's Copayment, in which case, the Member must pay the Prescription Drug cost and sales tax.
 17. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Member's home or vehicle.
 18. Charges for the delivery of health care, diagnosis, consultation, or treatment of a Member unless the Provider is physically present with the Member at the time services are rendered are not covered unless approved by Us. Covered Services delivered using technology, including but not limited to audio and video transmission, telephone or email, may be subject to Authorization as shown in the Schedule of Benefits.
 19. Charges for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.
 20. Routine foot care; palliative or cosmetic care or treatment; treatment of flat feet. Except for persons who have been diagnosed with diabetes: cutting or removal of corns and calluses, nail trimming or debriding, or supportive devices of the foot.
 21. Any abortion other than to save the life of the mother.
 22. Services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits.
 23. Services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.

24. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.
25. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.
26. Cosmetic Surgery, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly. Complications resulting from any of these or any other non-covered items are excluded.
27. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits.
28. Diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition.
29. Medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.
30. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.
31. Educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This exclusion for educational services and supplies does not apply to training and education for diabetes.
32. Admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician's office.
33. Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.
34. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.
35. Hospital charges for a well newborn.
36. Services or supplies for the treatment of alcohol and/or drug abuse, unless shown as Covered Services in the Schedule of Benefits.
37. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
38. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan.
39. Medical and surgical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).
40. Paternity tests and tests performed for legal purposes.
41. Genetic testing, unless the results are specifically required for a medical treatment decision on the Member.
42. Reversal of a voluntary sterilization procedure.
43. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us; all defibrillators other than implantable defibrillators Authorized by Us.
44. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.

45. Services or supplies for the prophylactic storage of cord blood.
46. Sleep studies, unless performed in the home or performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM). If a sleep study is performed in a sleep laboratory that is not accredited by one of these bodies, or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.
47. Applied Behavior Analysis (ABA) that the Company has determined is not Medically Necessary. ABA rendered to Members age twenty-one (21) and older. ABA rendered by a Provider that has not been certified as a behavior analyst by the Behavior Analyst Certification Board or rendered by a Provider that has not provided, to the satisfaction of Company, documented evidence of equivalent education, professional training, and supervised experience in ABA. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

ARTICLE XVIII. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

If eligibility for Group coverage ceases upon the death of the Subscriber, a surviving spouse covered as a Dependent who is fifty (50) years of age or older, has ninety (90) days from the date of the Subscriber's death to notify Company of his election to continue the same coverage for himself, and if already covered, for his Dependent children.

- Coverage is automatic during the ninety (90) day election period. Premium is owed for this coverage. If continuation is not chosen, or if premium is not received for the ninety 90 days of automatic coverage, the ninety (90) days of automatic coverage is terminated retroactive to the end of the billing cycle in which the death occurred.
- If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Premium is owed from the last date for which premium has been paid. No physical exams are required. Premium for continuing coverage will not exceed the premium assessed for each Subscriber by class of coverage under the Group Benefit Plan.

The Group will be responsible for notifying the spouse of the right to continue and for billing and collection of premium. However, if We have been furnished with the home address of the surviving spouse at the time of death and have been notified by the Group in a manner acceptable to Us of the death of the Subscriber, We will notify the surviving spouse of the right to continue.

Coverage continues on a premium-paying basis until the earliest of:

- the date premium is due and is not paid on a timely basis; or
- the date the surviving spouse or a Dependent child becomes eligible for Medicare; or
- the date the surviving spouse or a Dependent child becomes eligible to participate in another Group health plan; or
- the date the surviving spouse remarries or dies; or
- the date this Group Benefit Plan ends; or
- the date a Dependent child is no longer eligible.

B. State Continuation

This section (State Continuation) is available only if the Group is not subject to Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto.

A Subscriber or covered Dependent whose coverage under this Benefit Plan ends because of: 1) Subscriber's death; or 2) Subscriber's termination of active employment; or 3) because of the divorce of the Subscriber or a covered Member, may be entitled to continue the coverage under this Benefit Plan. The Subscriber or Dependent requesting continuation must have been continuously covered under this Benefit Plan (or another group policy that this Benefit Plan replaced) for the three (3) consecutive months immediately preceding the date this coverage would otherwise have ended.

Continuation of coverage for a Subscriber or his Dependents is **not** available if:

- the Covered Person, within thirty-one (31) days of termination of coverage, is or could have been covered by other Group coverage or a government sponsored health plan such as Medicare or Medicaid, or Group; or
- the Subscriber's or Member's coverage under this Benefit Plan terminated due to fraud or failure to pay his required contribution to premium; or
- the Covered Person is eligible for continuation of coverage under COBRA.

To elect continuation of coverage under this section, the Subscriber or Member must notify the Group in writing of his election to continue this Group health coverage and must pay any required contribution to the Group in advance. The initial contribution must be paid no later than the end of the month following the month in which the event occurred which made the Subscriber or Member eligible. (If the Dependent is eligible due to divorce, the event shall be deemed to have occurred on the date of the judgment of divorce.) A form to continue coverage is available from the Group.

Continuation of insurance under the Group policy for any Covered Person shall terminate on the earliest of the following dates:

- twelve (12) calendar months from the date coverage would have otherwise ended; or
- the date ending the period for which the Subscriber or Dependent makes his last required premium contribution for the coverage; or
- the date the Subscriber or Member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured, including Medicare or Medicaid; or
- the date on which the Group policy is terminated; or
- the date on which an enrolled Member of a health maintenance organization legally resides outside the service area of the Company.

C. COBRA Continuation

Benefits will be paid if required by the Uniformed Services Employment and Reemployment Rights Act of 1994 as amended (USERRA). The following provisions are applicable only if the employer is subject to the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) and any amendments thereto. See the Group Human Resources Manager for details about COBRA.

There may be other coverage options for You and Your family. When key parts of the health care law take effect, You will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what Your premium, Deductibles, and Out-of-Pocket costs will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage for a tax credit through the Marketplace. Additionally, You may qualify for a special enrollment opportunity for another group health plan for which You are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if You request enrollment within thirty (30) days.

Members must follow all notice and time period requirements or lose the right to COBRA Continuation Coverage.

If the Group requires shorter time periods than those stated herein, the shorter time periods of the Group apply.

In accordance with COBRA law, certain covered Subscribers and Dependents have the opportunity to continue their healthcare coverage without evidence of insurability when there is a "qualifying event" that would result in loss of coverage under an employer's plan.

These Subscribers and Dependents ("qualified beneficiaries") are those who are covered under this Benefit Plan on the day before a qualifying event occurs. In addition, a child who is born or placed for adoption with the covered Subscriber during a period of COBRA coverage will be eligible to become a qualified beneficiary if notification of such birth or adoption is made to the Group (in writing if required by the Group) within thirty (30) days of birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plans other participants or beneficiaries covered under the Plan, including special enrollment rights.

A "qualifying event" is any of the following events:

- termination of employment of a covered employee for reasons other than gross misconduct;
- loss of eligibility by a covered employee due to a reduction in the number of work hours of the covered employee;
- death of a covered Subscriber;
- a Dependent spouse's divorce or legal separation from a covered Subscriber;
- the covered Subscriber becomes entitled to Medicare Benefits resulting in the loss of coverage for Dependents;
- a Dependent child ceases to be an Eligible Dependent under the terms of this Benefit Plan; or
- the employer's Title 11 bankruptcy proceeding, with respect to covered employees who retired from the employer at any time.

To elect continuation coverage, the qualified beneficiary must complete a COBRA election form and furnish it to the Group within sixty (60) days of the qualified event. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several or for all Dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of the Dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

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

A Member may be required to pay the entire cost of continuation coverage (including both employer and employee contributions) plus an amount to cover administrative expenses. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Member otherwise would lose coverage under the Group health plan (the termination date); and

- ends sixty (60) days after the termination date or sixty (60) days after the Member is notified of their right to continue coverage. Member's election form must be given to Group no later than this sixtieth (60th) day of Group's notification to Member.

If continuation of coverage is elected, the qualified beneficiary must make his first payment for continuation coverage within forty-five (45) days after the date of the election. If the qualifying beneficiary does not make the correct first payment in full within the forty-five (45) day period, all COBRA continuation coverage rights are lost. Timely monthly payments are required thereafter to keep coverage. Member may not receive notice of payments due.

Continuation of coverage begins on the termination date and ends no earlier than:

- Eighteen (18) months after the termination date in the case of termination of employment or reduction in work hours. When the qualifying event is the end of employment or reduction of the employee's work hours, and the employee became entitled to Medicare Benefits less than eighteen (18) months before the qualifying event, COBRA continuation of coverage for qualified beneficiaries other than the employee lasts the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event.

NOTE: The eighteen (18) months may be extended to twenty-nine (29) months if a qualified beneficiary who is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) before the first day of COBRA coverage or becomes disabled during the first sixty (60) days of COBRA coverage.

This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. The qualified beneficiary must notify the Group of the disability determination before the end of the initial eighteen (18) month COBRA period and within sixty (6) days from:

- the date of the notice from the Social Security Administration of the determination of disability; or
- the date of the qualifying event;

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

- thirty-six (36) months after the date of termination due to any other qualifying event; or
- the date the employer ceases to maintain any Group health plan for its employees; or
- the date coverage ceases because of nonpayment of required premiums when due; or
- the date the Subscriber or Dependent first becomes covered after the date of the COBRA election under another Group health plan and Benefits under that plan are not excluded or limited with respect to a Pre-Existing Condition; or
- the date the Subscriber or Dependent becomes entitled to Medicare (under Part A, Part B, or both) after the date, he elects COBRA coverage.

NOTE: Special rules may apply for the duration of coverage under COBRA for certain retirees and their Dependents who lose coverage because of an employer's bankruptcy, which is a "qualifying event." In this event, certain retirees and certain Dependents of retirees who are deceased at the time of the qualifying event, may elect lifetime COBRA coverage as of the date of the bankruptcy proceeding. Otherwise, eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including but not limited to: the employer ceases

to provide any Group health plan to any employees or the qualified beneficiaries fail to pay the required premiums or become covered under another employer's Group health plan that does not exclude or limit Benefits for a qualified beneficiary's Pre-Existing Conditions.

NOTE: There are limitations on plans imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act.

Second Qualifying Event:

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

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

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

Keep Your Plan Informed of Address Changes

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

ARTICLE XIX.

COORDINATION OF BENEFITS

A. Applicability

- 1 This Coordination of Benefits ("COB") section applies to This Plan when a Member 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."

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) per day;
 - b. government programs, including compulsory no-fault automobile insurance, unless an applicable law forbids coordinating Benefits with this type of program;
 - c. labor-management trustee plans, union welfare plans, employer organization plans, employee benefit organization plans, and professional association plans;
 - d. any other employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended;
 - e. Medicare as permitted by federal law;
 - f. group-type plans or policies which can be obtained only because of employment with or membership in a particular organization, corporation, or other business entity.

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

Each plan or other arrangement for coverage is a separate plan. If an arrangement has two (2) parts and COB rules apply only to one (1) 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 (1) or more other plans, and may be a Secondary Plan as to a different plan or plans.

4. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one (1) or more plans covering the person for whom the Claim is made.

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

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

- 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, Member or Subscriber (or as that person's 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, Member or Subscriber 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. Blue Cross and Blue Shield of Louisiana has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield of Louisiana need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Blue Cross and Blue Shield of Louisiana any facts it needs to pay the Claim.

F. Facility of Payment

A payment made under another plan may include an amount, which should have been paid under This Plan. Blue Cross and Blue Shield of Louisiana 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 Blue Cross and Blue Shield of Louisiana 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 Blue Cross and Blue Shield of Louisiana made is more than it should have paid under this COB section, Blue Cross and Blue Shield of Louisiana 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 XX. GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP/POLICYHOLDER AND ALL MEMBERS.

The Group enters into this Benefit Plan on behalf of the eligible individuals enrolling under this Benefit Plan. Acceptance of this Benefit Plan by the Group is acceptance by and binding upon those who enroll as Subscribers and Dependents.

A. The Benefit Plan

1. This Benefit Plan, including the Employee Enrollment/Change Form and Schedule of Benefits, expressing the entire money and amendments or endorsements, constitutes the entire contract between the parties.
2. Except as specifically provided herein, this Benefit Plan will not make the Company 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 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 the Company 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 Company harmless in the event the Company incurs any liability as a result of the Group's failure to do so.
3. The Company 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 Member care or treatment.
4. The Company has full discretionary authority to determine eligibility for Benefits and/or to construe the terms of this Benefit Plan.

5. The Company 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 Company under this Benefit Plan may be performed by the Company or any of its subsidiaries, affiliates, subcontractors, or designees.

B. Benefit Plan Changes

Subject to all applicable laws and regulations, the Company reserves the right to modify the terms of this Benefit Plan. Changes will be effective upon renewal of the Contract and preceded by not less than sixty (60) days notice to the Group. No change or waiver of any Benefit Plan provision will be effective until approved by the Company's chief executive officer or his delegate.

C. Identification Cards and Benefit Plans

We will prepare an identification (ID) card for each Subscriber. We will issue a Benefit Plan to the Group and print a sufficient number of copies of the Benefit Plan for Group's Subscribers. At the direction of Group, We will either deliver all materials to the Group for Group's distribution to the Subscribers, or We will deliver the Subscriber materials directly to each Subscriber. The Subscriber's copy of the Benefit Plan shall serve as his certificate of coverage. Unless otherwise agreed between the Group and Us, the Group has the sole responsibility for distributing all such documents to Subscribers.

D. Benefits to Which Members are Entitled

1. The liability of the Company is limited to the Benefits specified in this Benefit Plan.
2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

E. Notice of Member Eligibility - Employer's Personnel Data

1. The Group is solely responsible for furnishing the information that We require for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations, and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate Us to provide Benefits under this Benefit Plan.
2. All notification of membership or coverage changes must be on forms that We approve and include all information required by Us to effect changes.
3. The Group must notify Our Membership and Billing Department of a Member's termination of coverage by completing a cancellation form (or other form of notification acceptable to Us) and submitting it to Our offices. For Subscriber, We must receive the cancellation form by the end of the billing cycle immediately following the billing cycle in which the Subscriber is terminated from Group employment or eligibility for coverage ends (or any other period described in the Schedule of Benefits). For Dependents, We must receive the cancellation form by the end of the billing cycle immediately following the billing cycle in which Dependent no longer meets eligibility for coverage (or any other period described in the Schedule of Benefits). The Group must submit evidence of a Member's election of available continuation of coverage to Our Membership & Billing Department following such termination within three (3) business days of Group's receipt of signed continuation forms from the Member. Company is under no obligation to refund any premium paid by Group or any Member, if payment was made to Company due to Group's failure to timely notify Company of a Member's termination of coverage.
4. Requests for termination of coverage that are submitted after the period provided above will only be honored prospectively after the date of receipt and the Group will be responsible to pay all corresponding premiums until the effective date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply. Whenever the Group submits a request to Company to terminate a Member's coverage or that of any of Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his Dependent has made payments towards the cost of premiums for any coverage period beyond the date on which the Group desires

the coverage to be terminated, and that no information was given or representation was made to the Member or his Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual for continuation coverage in a separate process.

5. The Group warrants the accuracy of the information it transmits to Us and understands that We will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as requested by Us.
6. The Group further agrees to indemnify Us for all expenses We may incur as a result of the Group's failure to transmit correct information in the time period that We require. Indemnification includes but is not limited to, Claims payments made on behalf of individuals that are not eligible for Benefits. Alternatively, the Company may, at its sole option, hold the Group responsible for all premium payments for Members who are not timely cancelled from coverage due to the Group's failure to timely notify the Company of terminations or changes in eligibility.

F. Termination of a Member's Coverage

1. The Company may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this policy. The issuance of this coverage is conditioned on the representations and statements contained at 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 Subscriber or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the Effective date of coverage or terminated within three (3) years of the Member's Effective Date, for fraud or intentional misrepresentation of material fact. Company will give the Member 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, a Member's coverage terminates as provided below:
 - a. The Subscriber's coverage and that of all his Dependents automatically, and without notice, terminates at the end of the billing cycle in which the Subscriber ceases to be eligible.
 - b. The coverage of the Subscriber's spouse will terminate automatically and without notice at the end of the billing cycle for which premiums have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.
 - c. The coverage of a Dependent will terminate automatically, and without notice, at the end of the billing cycle in which the Dependent ceases to be an eligible Dependent, if premiums have been paid through that period.
 - d. Upon the death of a Subscriber, 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. 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 or We terminate this Benefit Plan for nonpayment of the appropriate payment when due or because the for the Group fails to perform any obligation required by this Benefit Plan, such cancellation or termination alone will operate to end all rights of the Member to Benefits under of this Benefit Plan as of the Effective Date of such cancellation or termination. The Group shall have the obligation to notify its Members, participants, and beneficiaries of such cancellation or termination. We shall have no such obligation of notification at the Member level.

4. In the event of the occurrence of the provisions of paragraphs a., b., c. or d. above, if the Member is an Inpatient in a Hospital on the date coverage ends, medical Benefits in connection with the Admission for that patient will end at the end of that Admission, or upon reaching any Benefit limitations set in this Benefit Plan, whichever occurs first.
5. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Member for Covered Services rendered after the date of cancellation or termination of a Member's coverage.
6. We reserve the right to automatically change the Subscriber's class of coverage to reflect when no more children or grandchildren are covered under this Benefit Plan.
7. Cancellation or termination will be effective at midnight on the last day of the billing cycle. Billing cycles are from the 1st to the end of the month or from the 15th of the month to the 14th of the following month.
8. When the Group's coverage ends because the plan ceases to exist or COBRA is exhausted, the Louisiana Health Plan (LHP) can be contacted regarding possible health coverage for eligible individuals. For detailed information regarding price and available Benefits, Members may write to LHP at P.O. Drawer 83880, Baton Rouge, LA 70884-3880 or may call LHP at (225) 926-6245 or (800) 736-0947. Timeliness of communication with LHP is important.

G. Filing of Claims

1. A Claim is a written or electronic proof of charges for Covered Services that have been incurred by a Member during the time period the Member was covered under this Benefit Plan. We encourage Providers to file claims in a form acceptable to the Company within ninety (90) days from the date services are rendered, but no later than fifteen (15) months after the date of service. Benefits will be denied for Claims filed any later than fifteen (15) months from the date of service. Benefit Plan provisions in effect at the time the service or treatment is received shall govern the processing of any Claim filed or expense actually incurred as a result of the service or treatment rendered.
2. Most Members that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Member. However, if the Member must file a claim to access his Prescription Drug Benefit, the Member must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The claim form should then be sent to Our Pharmacy Benefit Manager, whose telephone number should be found on the Member's ID card.

H. Applicable Law

This Benefit 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 Benefit 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 the any applicable statutes of the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute.

I. 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 fifteen (15) months after the date services are rendered.

J. Release of Information

We may request that the Member or the Provider furnish certain information relating to the Member's claim for Benefits. We will hold such information, records, or copies of records as confidential except where in Our discretion the same should be disclosed.

K. Assignment; Non-Participating Hospital Penalty

1. A Member's rights and Benefits under this Benefit Plan are personal to the Member and may not be assigned in whole or in part by the Member. We will recognize assignments of benefits to Hospitals if both this Benefit Plan and the Provider are subject to La. R.S. 40:2010. If both this Benefit Plan and the Provider are not subject to La. R.S. 40:2010, We will not recognize assignments or attempted assignments of benefits. Nothing contained in the written description of health coverage shall be construed to make the health plan or Us liable to any third party to whom a Member may be liable for the cost of medical care, treatment, or services.
2. We reserve the right to pay PPO Providers and Hospitals, and Providers and Hospitals in Our Participating Provider Network directly instead of paying the Member.
3. When a Non-Participating Hospital renders Covered Services to a Member, the Company may reduce its Benefit payment by thirty percent (30%). The Company will not reduce its Benefit payment if the Covered Services rendered to a Member by the Non-Participating Hospital were not available from a Participating Hospital. The reduction in Benefits also will not be applied if the Covered Services rendered to a Member by the Non-Participating Hospital were Emergency Medical Services.

L. Member/Provider Relationship

1. The choice of a Provider is solely the Member's.
2. The Company 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 Company does not render Covered Services, but only makes payment for Covered Services for which the Member receives. The Company will not be held liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider or in any Network Provider's facilities. The Company has no responsibility for a Provider's failure or refusal to render Covered Services to the Member.
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.

M. This Benefit Plan and Medicare

1. For employers having twenty (20) or more active employees, federal law and regulations require that each active employee age sixty-five (65) or older, and each active employee's spouse age sixty-five (65) or older, may elect to have coverage under this Benefit Plan or under Medicare.
 - a. Where such employee or such spouse elects coverage under this Benefit Plan, this Benefit Plan will be the primary payor of Benefits with the Medicare program the secondary payor.
 - b. This Benefit Plan will not provide Benefits to supplement Medicare payments for Medicare eligible expenses for an active employee age sixty-five (65) or older or for a spouse age sixty-five (65) or older of an active employee where such employee or such spouse elects to have the Medicare program as the primary payor.
2. Under federal law, if an active employee under age sixty-five (65) or an active employee's Dependent under age sixty-five (65) is covered under a Group Benefit Plan of an employer with one hundred (100) or more employees and also has coverage under the Medicare program by reason of Social Security disability, the Group Benefit Plan is the primary payor and Medicare is the secondary payor.
3. For persons under age sixty-five (65) who are covered under this Benefit Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Benefit Plan the secondary payor, except that during the first thirty (30) month period that such persons are eligible for Medicare Benefits solely by reason of end-stage renal disease, this Benefit Plan will be the primary payor and Medicare the secondary payor.

4. When this Benefit Plan is the primary payor, it will provide regular Benefits for Covered Services. When this Benefit Plan is the secondary payor, it will provide Benefits based on the lesser of: the Medicare approved amount or the Company's Allowable Charge. When an Allied Provider or Physician is not required by Medicare to accept the Medicare approved amount as payment in full, We will base Benefits on the lesser of: the Medicare approved amount plus Medicare's limiting charge, if applicable, or the Company's Allowable Charge.

N. Notice

Any notice required under this Benefit Plan must be in writing. Notice given to the Group will be sent to the Group's address stated in the Application for Group Coverage. Notice given to the Company will be sent to the Company's address stated in the Application for Group Coverage. Any notice required to be given will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Member at his address as the same appears on the records of the Company, or to the Group at the address as the same appears on the records of the Company. The Group, the Company, or a Member may, by written notice, indicate a new address for giving notice.

O. Job-Related Injury or Illness

The Group must report to the appropriate governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any legislation of any governmental unit. This Benefit 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 Company and a compensation carrier or employer makes any type of settlement with the Subscriber, with any person entitled to receive settlement where the Subscriber dies, or if the Subscriber's injury or illness is found to be compensable under law, the Group or Subscriber must reimburse the Company for Benefits extended or direct the compensation carrier to make such reimbursement. The Company will be entitled to such reimbursement even if the settlement does not mention or excludes payment for health care expenses.

P. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Company will be subrogated and will succeed to the right of the Member for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute such subrogation. Our right to recover shall be subordinate to the Member's right to be "made whole."

The Company will be responsible for its proportionate share of the reasonable attorney fees and costs actually incurred by the Member in pursuing recovery.

2. The Member will reimburse the Company all amounts recovered by suit, settlement, or otherwise from any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured, to the extent of the Benefits provided or paid under this Benefit Plan. The Company's right to reimbursement shall be subordinate to the Member's right to be "made whole." The Company agrees that it will be responsible for its proportionate share of the reasonable attorney fees and costs actually paid by a Member in pursuing recovery.
3. The Member will take such action, furnish such information and assistance, and execute such papers as the Company may require to facilitate enforcement of its rights, and will take no action prejudicing the rights and interest of the Company under this Benefit Plan. Company and its designees have the right to obtain and review Member's medical and billing records, if Company determines in its sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Benefit Plan.
4. The Member is required to notify the Company of any Accidental Injury.

Q. Right of Recovery

Whenever any payment for Covered Services has been made by the Company 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 Company for non-Covered Services, the Company will have the right to recover such payment from the Member or, if applicable, the Provider. As an alternative, the Company reserves the right to deduct from any pending Claim for payment under this Benefit Plan any amounts the Member or Provider owes the Company.

R. 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 Company to the extent the veteran would be eligible for Benefits for such care or services from the Company 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 Company 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 Company 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 Co

S. Liability of Plan Affiliates

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Plan constitutes a contract solely between the Group and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Blue Cross and Blue Shield of Louisiana to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Group, 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 Group for any of Blue Cross and Blue Shield of Louisiana's obligations to the Group created under this Benefit 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 this agreement.

T. Out-of-Area Services

The Company has a variety of relationships with other Blue Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of Our service area, the Claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between Us and other Blue Licensees.

Typically, when accessing care outside Our service area, You 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, You may obtain care from Non-Participating healthcare providers. Our payment practices in both instances are described below.

1. BlueCard® Program

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

Whenever You access covered healthcare services outside Our service area and the Claim is processed through the BlueCard® Program, the amount You 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 Us.

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

Estimated pricing and average pricing, 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 We use for Your Claim because they will not be applied retroactively to Claims already paid.

2. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard® Program, Your Claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount You pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price made available to Us by the Host Blue.

3. Non-Participating Healthcare Providers outside Our Service Area

When covered healthcare services are provided outside of Our service area by Non-Participating healthcare Providers, the amount You pay for such services is described below.

a. Member Liability Calculation

When covered healthcare services are provided outside of the Company’s service area by Non-Participating healthcare Providers, the amount(s) a Member 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 Member may be responsible for the difference between the amount that the Non-Participating healthcare Provider bills and the payment the Company will make for the Covered Services as set forth in this paragraph.

b. Exceptions

In some exception cases, the Company may pay Claims from Non-Participating healthcare Providers outside of the Company’s service area based on the Provider’s billed charge, such as in situations where a Member did not have reasonable access to a Participating Provider, as determined by the Company in Our sole and absolute discretion or by applicable state law. In other exception cases, We may pay such a Claim based on the payment We would make if the Company were paying a Non-Participating Provider inside of Our service area, as described elsewhere in this Benefit Plan, where the Host Blue’s corresponding payment would be more than the Company’s In-Service area Non-Participating provider payment, or in Our sole and absolute discretion, We may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the Non-Participating healthcare Provider bills and payment the Company will make for the Covered Services as set forth in this paragraph.

U. HIPAA Certificates of Creditable Coverage

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

1. We 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.
 - c. an individual who is a qualified beneficiary and has elected COBRA continuation of coverage that has ended.
2. We 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 Member should contact Our customer service department at the phone number shown on his ID card.

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

We shall provide to certain Members who have Prescription Drug coverage under this Benefit Plan, without charge, a written certification that their Prescription Drug coverage under this Benefit 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. We will provide these certificates to covered Group Members who are eligible for Medicare Part D based upon enrollment data provided to Us by the Group. Group is responsible for providing a certificate to applicants prior to the Effective Date of coverage for new Medicare-eligible persons that join this Benefit Plan.

We will provide Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to covered Members 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 Benefit Plan changes so that it is no longer creditable or becomes creditable; and/or
5. upon a Medicare beneficiary's request.

W. Continued Coverage When Employee Not Actively Working

As stated in the Schedule of Eligibility, an Employee must be actively working for his Employer/Group to be entitled to coverage under this Benefit Plan. Each of the following provisions are exceptions to the requirement that the Employee be actively working in order for coverage to apply. The following provisions are independent of each other and only one need apply for Subscriber and his Dependents to be entitled to continued coverage under this Plan.

1. Company will continue coverage for Subscriber during any leave of absence the Group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 (FMLA) and any amendments or successor provisions, as long as all other eligibility criteria under the law continues to be met. If Subscriber's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, Subscriber is entitled to re-enroll for coverage so long as the Group maintains coverage with Company. If the Subscriber is not restored to active full-time employment by the end of the leave of absence period, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will

terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.

2. When a Subscriber is not actively at work due to a health condition, Company will maintain coverage for the Subscriber and any Dependents, as long as the Subscriber remains a bona fide employee of the Group and premiums are paid. If Group terminates Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.
3. When a Subscriber has been granted a documented, approved leave of absence by the employer Group, and the leave of absence is not due to Subscriber's health, Company will maintain coverage for the Subscriber and any Covered Dependents for a period not to exceed ninety (90) days. Premiums must be paid and Subscriber must remain a bona fide employee of Group during the approved leave period. Group will provide Company with proof of the documented leave, upon request. If Group terminates Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.

ARTICLE XXI. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Member is unhappy about the care or services he receives from Blue Cross and Blue Shield of Louisiana or one of Our providers. If a Member wants to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

A Member may be unhappy about decisions We make regarding Covered Services. We consider the Member's request to change Our coverage decision as an Appeal. We define an Appeal as a request from a Member or authorized representative to change a previous decision made by the Company about covered services. Examples of issues that qualify as appeals include denied Authorizations, Claims based on adverse determinations of Medical Necessity, or Benefit determinations.

Your Appeal rights are outlined below, after the Complaint and Grievance procedure. In addition to the Appeals rights, the Member's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of Our coverage decision when they concern medical necessity determinations.

We have an Expedited Appeals process for situations where the time frame of the standard Appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. That process is outlined following the Standard Appeal Procedure.

Complaint and Grievance Procedure

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

To Register a Complaint

Call Our Customer Service Department at 1-800-599-2583 or 1-225-291-5370 to register a Complaint. We will attempt to resolve the Member's Complaint at the time of his call.

To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Member does not feel his Complaint was adequately resolved or he wishes to file a formal Grievance, the Member must submit this in writing. Our Customer Service Department will assist the Member if necessary.

The Member should send his written Grievance to:

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

A response will be mailed to the Member within thirty (30) business days after We receive the Member's written Grievance. If the Member is not happy with Our handling of his Grievance, the Member has the right to elevate his Grievance to the second and final level. A separate panel reviews each level of Grievance.

Written request of your second level Grievance must be received no later than sixty (60) calendar days from the date We notified You of the answer to the first level Grievance. Grievances received after this date will not be considered.

The second level Grievance request will be presented to the administrative Appeals and Grievances committee. Notice of Our final decision will be sent to You in writing within thirty (30) calendar days of Our receipt of Your request for a second level Grievance.

Informal Reconsideration

An Informal Reconsideration is the Member Provider's telephone request to speak to Our Medical Director or a peer reviewer on the Member's behalf about a Utilization Management decision that We have made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion. An Informal Reconsideration is available only for initial determinations that are requested within ten (10) days of the denial or Concurrent Review determinations. We will conduct an Informal Reconsideration within one (1) working day of the receipt of the request.

Appeal Procedures

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

Due to variations between federal and state laws, Appeals for ERISA members are handled differently from non-ERISA member appeals. Both ERISA and non-ERISA appeals processes are outlined below. The Member should contact his employer, Plan Administrator, Plan Sponsor, or Us at 1-800-599-2583 or 1-225-291-5370 if the Member is unsure which process applies to him. The Member may submit appeals or communicate with Us regarding any Appeal by writing to:

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

If a Member has questions or needs assistance putting the Appeal in writing, the Member may call Our Customer Service Department at 1-800-599-2583 or 1-225-291-5370. Providers will be notified of Appeal results only if the Provider filed the Appeal.

APPEAL PROCESS IF THE MEMBER IS NOT AN ERISA MEMBER

We will distinguish a Member's Appeal as either an administrative Appeal or a Medical Necessity Appeal. Depending on the amount at issue, Appeals for Investigational denials will follow either the administrative Appeal process, or the Medical Necessity Appeal process. The Appeals procedure has two (2) internal levels, including review by a committee at the second level. The Member is encouraged to provide Us with all available information to help Us completely evaluate the Member's Appeal. Medical Necessity Appeals also offer the Member the opportunity to appear in person or telephonically at a committee meeting as well as an opportunity for review by an independent external review organization.

The Member has the right to appoint an authorized representative to represent him in his Appeals. An authorized representative is a person to whom the Member has given written consent to represent him in an internal or external review of a denial.

The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing and the Provider agrees and waives in writing, any right to payment from the Member other than any applicable Copayment or Coinsurance amount.

Investigational Appeals

A Member appealing an Investigational denial will receive the process for an Informal Reconsideration and the process for first level Internal Appeals of Medical Necessity issues. The process to be followed beyond this level depends on whether the claim reaches the "Investigational Appeals Threshold."

An Investigational denial meets the "Investigational Appeals Threshold" when: (1) the Allowable Charge for the item or service exceeds five hundred dollars (\$500); (2) if the item or service is subject to FDA approval, it must be so approved; and, (3) if the item is not subject to FDA approval, use of the item or service must be supported by medical or scientific evidence.

If an Investigational denial meets the Investigational Appeals Threshold, the Member will follow the process for the second level of Internal Appeal for Medical Necessity issues and the independent external review for Medical Necessity. **Note: When a denial meets the Investigational Appeals Threshold, We may, in Our sole discretion, choose to bypass any or all Internal Appeal levels and send the Appeal directly to an independent external reviewer.**

If an Investigational denial does not meet the Investigational Appeals Threshold, the Member's Appeal will follow the process for administrative appeals.

First Level of Internal Appeal

The Member, his authorized representative, or a Provider acting on the Member's behalf, must submit his initial written request to Appeal within one hundred eighty (180) days following receipt of an initial adverse Benefit determination. Requests submitted to Us after one hundred eighty (180) days of Company's initial denial will not be considered.

We will investigate the Member's concerns. Health care professionals, including a Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review not previously involved in the initial decision, will review all Appeals of Medical Necessity denials. If We change Our original decision at the Appeal level, We will process the Member's claim and notify the Member and all appropriate providers, in writing, of the first level Appeal decision. If the Member's claim is denied on Appeal, We will notify the Member and all appropriate Providers, in writing, of Our decision within thirty (30) calendar days of the Member's request, unless We mutually agree that an extension of the time is warranted. At that time, We will inform the Member of the right to begin the second level Appeal process.

Second Level of Internal Appeal

Within sixty (60) calendar days of the date of Our first level Appeal decision, a Member who is not satisfied with the decision may initiate, with assistance from the Customer Service Unit, if necessary, the second level of Appeal process. Requests submitted to Us after sixty (60) days of the denial will not be considered.

A Member Appeals Committee not involved in any previous denial will review all second level Appeals. The Committee's decision is final and binding as to any administrative Appeal and will be mailed to the Member within five (5) working days of the Committee meeting. For Medical Necessity Appeals only, We will advise the Member or his authorized representative of the date and time of the review meeting, which the Member or his authorized representative may attend. The review meeting is normally held within forty-five (45) working days of Our receipt of the Member's request for a second level Appeal.

The Member or his authorized representative has the right to attend the review meeting for Medical Necessity Appeals, present his position, and ask questions of the Committee members present, subject to the rules of procedure established by the Committee. If the Member is unable to appear before the Committee, but wishes to participate, We will make arrangements for the Member to participate by means of available technology. For Medical Necessity Appeals, a Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review must agree with any adverse decision made by the Committee.

The Committee will mail its decision regarding the Member's Medical Necessity Appeal to the Member within five (5) working days after the meeting. Medical Necessity Appeals only can be elevated to the third and final review by an independent external review organization.

Independent External Review

If a Member still disagrees with the Medical Necessity denial, and has the concurrence of his treating Physician, the Member may request an independent External Appeal conducted by a non-affiliated Independent Review Organization (IRO). Within sixty (60) days of receipt of the second level Appeal decision, the Member should send his written request for an external review to Us. Requests submitted to Us after sixty (60) days of receipt of the denial will not be considered.

We will provide the IRO all pertinent information necessary to conduct the Appeal. The IRO decision will be considered a final and binding decision on both the Member and the Company. The IRO review will be completed within seventy-two (72) hours after the Appeal is commenced on both the Member and the Company if the request is of an urgent or emergent nature. Otherwise, the review will be completed within thirty (30) days from the receipt of the information from Us, unless the parties agree to a longer period. The IRO will notify the Member or his authorized representative and his health care Provider of its decision.

Expedited Internal Appeal

We provide an Expedited Internal Appeal process for review of an adverse determination involving a situation where the time frame of the standard Appeal would seriously jeopardize a Member's life, health or ability to regain maximum function.

In these cases, We will make a decision no later than seventy-two (72) hours after the review commences.

An Expedited Appeal is a request concerning an Admission, availability of care, continued stay, or health care service for a covered person who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility. Expedited Appeals are not provided for review of services previously rendered. An Expedited Appeal shall be made available to, and may be initiated by, the covered person or an authorized representative, with the consent of the covered person's treating health care Provider, or the Provider acting on behalf of the covered person.

Requests for an Expedited Internal Appeal may be oral or written and should be made to:

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

We must receive proof that the Member's Provider supports this request for an Expedited Internal Appeal. In any case where the Expedited Internal Appeal process does not resolve a difference of opinion between Us and the covered person or the Provider acting on behalf of the covered person, the Appeal may be elevated to a Second Level Standard Internal Appeal or an Expedited External Review.

Expedited External Review

An Expedited External Review is a request for immediate review, by an Independent Review Organization (IRO), of an adverse initial determination not to Authorize continued services for Members currently in the emergency room,

under observation in a facility or receiving Inpatient care. The Member's health care Provider must request the Expedited External Review. Expedited External Reviews are not provided for review of services previously rendered. An Expedited External Review of an adverse decision is available if pursuing the standard Appeal procedure could seriously jeopardize the Member's life, health or ability to regain maximum function.

Within sixty (60) days of the denial, the Provider should contact Us to request this level of review. We will forward all pertinent information to the IRO so the review is completed no later than seventy-two (72) hours after the review commences. Any decision rendered by the IRO is binding on Us and the Member. This Appeals process shall constitute the Member's sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary.

APPEAL PROCESS FOR ERISA MEMBERS

If a Member is an ERISA Member, We offer the Member two (2) levels of appeal. The Member is required to complete the first level of appeal prior to instituting any civil action under ERISA section 502(a). The second level of appeal is voluntary.

The two (2) levels of review for administrative Appeals will be internal. The first level of review for Medical Necessity Appeals will be internal and an external Independent Review Organization (IRO) that is not affiliated with Us will handle the second voluntary level of review. Any decision by an IRO is binding on both the insured and the Company.

The Member has the right to appoint an authorized representative to represent him in any Appeal. An authorized representative is a person to whom the Member has given written consent to represent the Member in an internal or external review.

The Member is encouraged to submit written comments, documents, records, and other information relating to the claim for Benefits. We will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his claim for Benefits.

Persons not involved in previous decisions regarding the Member's claim will decide all appeals. A Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review who is not subordinate to any previous decision maker on the Member's claim will review Medical Necessity appeals.

Investigational Appeals

A Member appealing an Investigational denial will receive the process for an Informal Reconsideration and the process for first level Internal Appeals of Medical Necessity issues. The process to be followed beyond this level depends on whether the claim reaches the "Investigational Appeals Threshold."

An Investigational denial meets the "Investigational Appeals Threshold" when: (1) the Allowable Charge for the item or service exceeds five hundred dollars (\$500); (2) if the item or service is subject to FDA approval, it must be so approved; and, (3) if the item is not subject to FDA approval, use of the item or service must be supported by medical or scientific evidence.

If an Investigational denial meets the Investigational Appeals Threshold, the Member will follow the process for the independent external review for Medical Necessity. **Note: When a denial meets the Investigational Appeals Threshold, We may, in Our sole discretion, choose to bypass any or all Internal Appeal levels and send the Appeal directly to an independent external reviewer.**

If an Investigational denial does not meet the Investigational Appeals Threshold, the Member's Appeal will follow the process for administrative Appeals.

First Level of Internal Appeal (Mandatory prior to instituting legal action)

The Member, his Authorized Representative, or Provider acting on the Member's behalf must submit his initial written request to Appeal within one hundred eighty (180) days following the Member's receipt of an initial adverse Benefit determination. Requests submitted after one hundred eighty (180) days of Company's initial denial will not be considered.

In the case of a claim involving urgent care as defined below, We will expedite the review process. The Member may request an expedited review orally or in writing. All necessary information may be transmitted between the parties by telephone, facsimile, or other available similarly expeditious means. We will review the Member's Appeal promptly. The Member will receive notice of Our review decision for:

1. Urgent care Claims as soon as reasonably possible taking into account medical exigencies, but not later than seventy-two (72) hours after We receive the Member's request for an Appeal of an adverse Benefit determination. ("Urgent care claim" means any claim with respect to which the application of the time periods for making non-urgent care determinations (a) could, in the opinion of a prudent person with an average knowledge of health or medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (b) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.)
2. Pre-service Claims within a reasonable period of time appropriate to the medical circumstances but not later than thirty (30) days after We receive the Member's request for Appeal of an adverse Benefit determination. ("Pre-service claim" means any claim for a Benefit under the plan with respect to which the terms of the plan condition receipt of the Benefit, in whole or in part, on approval or Authorization of the Benefit in advance of obtaining care or treatment.)
3. Post-service Claims within a reasonable period of time, but not later than thirty (30) days after We receive the Member's request for Appeal of an adverse Benefit determination. ("Post-service claim" means any claim for a Benefit under the plan that is not an Urgent Care Claim or a Pre-service Claim as defined.)

We may extend the initial period for review of a post-service claim by fifteen (15) days prior to the end of the initial thirty (30) day period if special circumstances require an extension of time. Any notice of extension will be in writing, explain the special circumstances that may dictate an extension of the time period needed to review the Member's Appeal and give the date by which We expect to make Our decision. In any event, however, the Member will receive written notice of Our decision no later than forty-five (45) days after the Member's request for review is received.

If Our initial decision is not overturned on Appeal, We will inform the Member in writing of his right to begin the voluntary second level Appeal process and any other ERISA rights that may be available to the Member at that time.

Second Level Administrative Appeal (Voluntary)

Within sixty (60) calendar days of the date of Our first level administrative Appeal decision, a Member who is not satisfied with the decision may initiate a voluntary second level of Appeal process. Requests submitted to Us after sixty (60) days of the denial will not be considered.

It is not necessary to complete this voluntary process in order to bring a civil action under ERISA section 502(a). Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Member's decision whether or not to submit to this voluntary level of review will have no effect on the Member's rights to any other Benefits under the plan. No fees or costs will be imposed on the Member.

The second level appeal will involve a committee review not previously involved in the Member's claim determination. The committee will mail its decision to the Member within five (5) working days after the meeting. The result of this committee is the final review decision for Claims not involving medical necessity determinations.

Second Level Medical Necessity Appeal (Voluntary)

Within sixty (60) calendar days of the date of Our first level Medical Necessity Appeal decision, a Member who is not satisfied with the decision may initiate a voluntary second level of Appeal process. Requests submitted to Us after sixty (60) days of the denial will not be considered.

If the Member wishes to elevate his Appeal of a Medical Necessity denial to the second and final level, a non-affiliated external IRO will perform the Member's review. It is not necessary to complete this voluntary process in order to bring a civil action under ERISA section 502(a). Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Member's decision whether or not to submit to this voluntary level of review will have no effect on the Member's rights to any other Benefits under the plan. No fees or costs will be imposed on the Member.

The Member's Provider may make the request for an expedited external review if the Member's medical condition is of an urgent or emergent nature. Expedited reviews will be completed within seventy-two (72) hours after the Appeal is commenced. Otherwise, the Member will need to have the concurrence of his treating Physician to request the external review.

The Member may request this level of Appeal by sending a written request for an external review to Us within sixty (60) days of receipt of a level one denial. Requests submitted to Us after sixty (60) days of receipt of denial will not be considered. Members are entitled to only one IRO Appeal. We will provide the IRO all necessary documents and information used in making the adverse determination to the IRO. The review will be completed within thirty (30) days from the IRO's receipt of information from Us, unless the parties agree to a longer period. The IRO will notify the Member or his authorized representative and his health care Provider of its decision. The decision of the IRO is binding on both the insured and the Company.

ARTICLE XXII.

ERISA RIGHTS

To the extent this is an ERISA plan, the Member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For purposes of this provision, the Group is considered the Plan Administrator and will be subject to the provisions stated below. ERISA provides that all plan participants (Members) shall be entitled to:

Receive Information about the Plan and Benefits

- A participant may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Upon written request to the Plan Administrator, a participant may obtain copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- A participant may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- A plan participant may continue health care coverage for himself, his spouse, or his Dependents, if there is a loss of coverage under the plan as a result of a qualifying event. The participant or Dependents may, however, have to pay for such coverage. A participant may also review this document and the Summary Plan Description governing the plan on the rules pertaining to the participant's COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the participant and other beneficiaries. No one, including his employer, union or any other person, may fire him or otherwise discriminate against him in any way to prevent him from obtaining a plan benefit or exercising his rights under ERISA.

Enforce Participant's Rights

- If a participant's claim for a plan Benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.
- Under ERISA, there are steps the participant can take to enforce the above rights. A participant must exhaust all claims and appeal procedures available to him before filing any suit. For instance, if the participant requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the participant may file suit in Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to one hundred ten dollars (\$110.00) a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the participant has a claim for Benefits, which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if he disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such participant may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if the participant is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person he has sued to pay these costs and fees. If the participant loses, the court may order him to pay these costs and fees, for example, if it determines that his claim is frivolous.

Assistance with Participant Questions

- If a participant has any questions about his plan, he should contact the Plan Administrator. If a participant has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The participant may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XXIII.

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

Blue Cross and Blue Shield of Louisiana is continuing to update its online access for Members. Members may now be able to perform many of the functions described below, without contacting Our Customer Service Unit. We invite Members 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 Our local service offices*, or from the home office of Blue Cross and Blue Shield of Louisiana. The Change of Status Card has the health questionnaire on the reverse side.

If the Member needs to submit documentation to Us, the Member may forward it to Our home office at Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA70898-9029, or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Member has any questions about any of the information in this section, the Member may speak to his employer or call Our Customer Service Department at the telephone number shown on his ID card.

HOW TO OBTAIN CARE WHILE TRAVELING

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

1. In an Emergency, go directly to the nearest Hospital.

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

CHANGING FAMILY MEMBERS ON THE MEMBER'S POLICY

The Schedule of Eligibility lets the Member know when it is necessary for the Member to apply for coverage to enroll additional family members to the Member's policy. Please read the Schedule of Eligibility and this section as they contain important information for the Member.

The Change of Status Card is the document that We must receive in order to enroll family members not listed on the Member's original application/enrollment form. The Schedule of Eligibility will tell the Member whether We require the Change of Status Card and/or the health questionnaire. Because the Member is covered under a Group insurance contract, it is extremely important that the Member follow the timing rules in the Schedule of Eligibility for making these changes to the Member's policy. If the Member does not complete and return a required Change of Status Card to Us so We receive it within the timeframes set out in the Schedule of Eligibility, it is possible that the Member's insurance coverage will not be expanded to include the additional family members. Completing and returning a Change of Status Card is especially important when the Member's first Dependent becomes eligible for coverage or when the Member no longer has any eligible Dependents.

If the Member has any changes in his family, the Member must file a Change of Status Card. The Member may also be asked to complete the health questions for these family members. The Schedule of Eligibility explains when coverage becomes effective for new family members. Generally, a Change of Status Card is used to add newborn children, newborn adopted children, a spouse, or other Dependents not listed on the Member's original application for coverage. We should receive the Member's completed form in Our home office within thirty (30) days of the child's birth or placement, or the Member's marriage.

HOW TO FILE INSURANCE CLAIMS FOR BENEFITS

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

The Member's Blue Cross and Blue Shield of Louisiana ID card) shows the way the name of the Subscriber (Member of the Group) appears on the Company records (If the Member has Dependent coverage, the name(s) are recorded as shown in the enrollment information We received.) The ID card also lists the Member's Contract number (ID #). This number is the identification to the Member's membership records and should be provided to Us each time a claim is filed.

To assist in promptly handling the Member's Claims, the Member must be sure that:

- a. an appropriate claim form is used
- b. the Contract number (ID #) shown on the form is identical to the number on the ID card
- c. the patient's date of birth is listed
- d. the patient's relationship to the Subscriber is correctly stated
- e. all charges are itemized, whether on the claim form or on the attached statement
- f. the date of service (Admission to a Hospital or other Provider) or date of treatment is correct
- g. the Provider includes a diagnosis and procedure code for each service/treatment rendered
- h. the claim is completed and signed by the Member and the Provider.

IMPORTANT NOTE:

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

ADDITIONAL INFORMATION FOR FILING SPECIFIC CLAIMS

Admission to a Hospital or Allied Health Facility Claims

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

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 Member. If this occurs, the Member 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 Subscriber. The Provider must mark the statement or claim form PAID. This statement should then be sent to Blue Cross and Blue Shield of Louisiana.

Prescription Drug Claims

Most Members with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Members who presents his ID card to a Participating Pharmacist. However, if the Member must file a claim to access the Member's Prescription Drug Benefit, the Member must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The claim form should then be sent to Blue Cross and Blue Shield of Louisiana Our Pharmacy Benefit Manager, whose telephone number should be found on the Member's ID card.

Benefits will be paid to the Member based on the Allowable Charge for the Prescription Drug.

Other Medical Claims

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

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

IMPORTANT NOTE: 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.

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 R.N. or L.P.N. 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.

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.

Mental Health or Substance Abuse Claims

For help with filing a Claim for Mental Health or substance abuse, the Member should refer to his ID card or call Our Customer Service Department.

IF A MEMBER HAS A QUESTION ABOUT HIS CLAIM

If a Member has a question about the processing or payment of a claim, the Member can write Us at the below address or the Member may call Our Customer Service Department at the telephone number shown on his ID card or any of Our local service offices*. If the Member calls for information about a claim, We can help the Member better if the Member has the information at hand--particularly the Contract number, patient's name and date of service.

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

Remember, the Member must ALWAYS refer to the his Contract number in all correspondence and recheck it against the Contract number on the Member's 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 XXIV. GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

IN ADDITION TO THE GENERAL PROVISIONS FOR GROUP/POLICYHOLDER AND MEMBERS, THE FOLLOWING GENERAL PROVISIONS WILL ALSO APPLY TO THE GROUP/POLICYHOLDER.

A. Due Date for Group's Premium Payments

1. Premiums are due and payable from Group/Policyholder in advance, prior to coverage being rendered. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. This is the premium due date.
2. Premiums are owed by Group/Policyholder. Premiums may not be paid by third parties, including but not limited to Hospitals, Pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. Company will not accept premium payments by third parties unless required by law to do so. The fact that Company may have previously accepted a premium from an unrelated third party does not mean that Company will accept premiums from these parties in the future.
3. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean We will accept late premiums in the future. You may not rely on the fact that We may have previously accepted a late premium as indication that We will do so in the future.
4. Premiums must be paid in US dollars. Policyholder will be assessed a twenty-five dollar (\$25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage.

B. Change in Premium Amount

1. Premiums for this Benefit Plan may increase after the Group's first twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, We will give Group forty-five (45) days written notice of any change in premium rates (ninety (90) days written notice for employer groups with more than 100 enrolled employees). We will send notice to the Group's latest address shown in Our records. Any increase in premium is effective on the date specified in the rate change notice. Continued payment of premium will constitute acceptance of the change.
2. We reserve the right to increase the premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Benefit Plan. This risk includes, but is not limited to, the right to increase the premium amount because of: (1) the addition of a newly covered person; (2) the addition of a newly covered entity; (3) a change in age or geographic location of any individual insured or policyholder; (4) or a change in the policy Benefit level from that which was in force at the time of the last rate determination. An increase in premium will become effective on the next billing date following the effective date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

C. Group to Distribute and Account for Premium Rebate

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Group/Policyholder the total rebate applicable to the Policy, and Group, on behalf of the Company, will distribute from the rebate a pro-rata share of the rebate to each Subscriber (including but not limited to employees, retirees, and elected officials as covered on the Group's Benefit Plan) based upon their contribution to the premium rebated. Group shall assure appropriate notification to federal and state tax agencies and that each payment to Subscribers will be accompanied by appropriate federal and state documentation, e.g. Form 1099. Group shall develop and retain records and documentation evidencing accurate distribution of any rebate and shall provide such records to Company upon request. Such records shall include:

1. the amount of the premium paid by each Subscriber;
2. the amount of the premium paid by the Group;
3. the amount of the rebate provided to each Subscriber;
4. the amount of the rebate retained by the Group; and
5. the amount of any unclaimed rebate and how and when it will be or was distributed.

Group will assure that any unclaimed rebate amounts will be reported in accordance with the unclaimed property laws of the applicable Subscriber's state of domicile. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this Section of the Group Health Benefit Plan.

D. Group's Right to Cancel the Policy

1. This policy is guaranteed renewable at the option of the Group. Group indicates its desire to continue coverage by its timely payment of each premium as it becomes due.
2. Group may cancel this policy for any reason.
3. To cancel the policy, Group must give Company WRITTEN NOTICE of its intent to cancel. GROUP MAY NOT VERBALLY CANCEL THIS COVERAGE. GROUP'S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE INSURANCE POLICY. If Group's written notice to Company of its intent to cancel is not accompanied by the surrendered policy, Group's cancellation notice to Company shall be deemed to include Group's declaration that the Group made a good faith attempt to locate its policy and the policy is not returned because it has been lost or destroyed.

E. Company's Right to Terminate the Policy for Nonpayment of Premium

1. Premiums are to be prepaid before coverage is rendered. The Group is considered delinquent if premiums are not paid on the due date.
2. The Company offers a thirty (30) day grace period (delinquency period) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the policy. If We do not receive the premium during the grace period, We will mail a delinquency/termination notice to the Group's address of record. We may automatically terminate the policy without further notice to the Group if We do not receive Group's premium at Our home office within thirty (30) days of the due date (during the grace period). If We terminate this Benefit Plan for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

F. Company's Right to Terminate the Policy for Reasons Other Than Nonpayment of Premium

1. Company may terminate this Benefit Plan if any one of the following occurs:
 - a. Group commits fraud or makes an intentional misrepresentation.
 - b. Groups fail to comply with a material plan provision, including, but not limited to provisions relating to eligibility, employer contributions or group participation rules. If the sole reason for termination is that Group's participation falls to less than two (2) employees (there is only one (1) employee covered (or owner, if covered), termination of Group coverage will be effective on the Group's next anniversary date. Otherwise, termination for a reason addressed in this paragraph will be effective after Group receives sixty (60) days written notice as described below.
 - c. In the case of network plans, there is no longer any enrollee under the Group benefit plan that lives, resides, or works in the service area of the Company or in the area for which the Company is authorized to do business.
 - d. Group's coverage is provided through a bona fide association and the employer's membership in the association ends.
 - e. Company ceases to offer this product or coverage in the market.
2. If Company terminates this coverage because of a, b, c, or d, We will give Group written notice at least sixty (60) days in advance. Company will give notice by certified mail and shall include the reason for termination. Notice of termination because of e will be sent to the Group by regular mail ninety (90) days in advance of termination.

G. Proxy Votes

Election of the Board of Directors of the Plan and certain significant corporate transactions are determined by majority vote of its policyholders, unless a different vote is required by law or the Plan's Articles of Incorporation or Bylaws. A policyholder designates, by means of the application for coverage, the members of the Board of Directors of the Plan as his proxy to vote on these important matters. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder. This proxy may be revoked by the policyholder by giving written notice of the revocation. This revocation may be in any form of writing either revoking the proxy or designating a different proxy and must be sent to the Plan at P.O. Box 98029, Baton Rouge, Louisiana 70898-9029. In lieu of giving his proxy on the application for coverage, the policyholder may designate any other policyholder as his proxy by any form of writing which includes the policyholder's name and policy number, sent to the Plan as indicated above. Notice of meetings to the proxy constitutes notice to the policyholders giving their proxies. Further, notice is hereby given that the annual meeting of the Plan is held on the third Tuesday in February or on the next business day following, if a legal holiday. However, additional notice of meetings will be sent to any policyholder or his proxy upon his written request for such notice directed to the Company's secretary.

H. Out-of-Area Services

The Company has a variety of relationships with other Blue Licensees referred to generally as “Inter-Plan Programs.” Whenever Members access healthcare services outside the geographic area the Company serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to the Company for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Benefit Plan are described generally below.

Typically, Members, when accessing care outside the geographic area the Company serves, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Licensee in that other geographic area (“Host Blue”). In some instances, Members may obtain care from Non-Participating healthcare providers. The Company’s payment practices in both instances are described below.

1. BlueCard® Program

Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue, the Company will remain responsible to the Member for fulfilling its contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers.

The financial terms of the BlueCard® Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Our action will be consistent with the spirit of this description.

a. Liability Calculation Method Per Claim

The calculation of the Member liability on Claims for covered healthcare services processed through the BlueCard® Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to the Company by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s healthcare provider contracts. The negotiated price made available to the Company by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

- (1) an actual price. An actual price is a negotiated payment without any other increases or decreases, or
- (2) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or
- (3) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for Claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims. The BlueCard® Program requires that the price submitted by a Host Blue to the Company is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Company would then calculate Member liability in accordance with applicable law.

b. Return of Overpayments

Under the BlueCard® Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a Claim-by-Claim or prospective basis.

2. Negotiated National Account Arrangements

As an alternative to the BlueCard® Program, Your Member Claims for covered healthcare services may be processed through a negotiated national account arrangement with a Host Blue.

If the Company has arranged for (a) Host Blue(s) to make available (a) custom healthcare provider Network(s) in connection with this Benefit Plan, then the terms and conditions set forth in the Company's negotiated national account arrangement(s) with such Host Blue(s) shall apply.

Member liability calculation will be based on the lower of either billed covered charges or negotiated price made available to the Company by the Host Blue that allow Members access to negotiated participation agreement Networks of specified participating healthcare providers outside of the Company's service area.

3. Non-Participating Healthcare Providers outside The Company's Service Area

When covered healthcare services are provided outside of the Company's service area by Non-Participating healthcare providers, the amount(s) a Member pays for such services is described in the Member section of this Group Health Benefit Plan booklet.

I. Health Insurance Portability and Accountability Act (Privacy and Security)

1. For purposes of this provision, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

- a. "Group Health Plan" as defined at 45 CFR Part 160, Sec. 160.103.
- b. "Protected Health Information" (PHI) as defined at 45 CFR Part 164, Sec. 164.501.
- c. "Summary Health Information" as defined at 45 CFR Part 164, Sec. 164.504(a).

2. Disclosing Information to the Group

a. Sharing Summary Health Information With the Group:

The Company may disclose Summary Health Information to the Group if the Group requests Summary Health Information for purposes of obtaining premium bids from health insurers, HMOs or other third party payers under the Group Health Plan; or modifying, amending or terminating the Group Health Plan.

b. Sharing PHI with the Group:

The Company may disclose PHI to the Group to enable the Group to carry out plan administration functions only upon receipt of a certification from the Group that:

- (1) its plan documents include all of the requirements set forth in 45 CFR Part 164, Sec. 164.504(f)(2)(i), (ii) and (iii);
- (2) it has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520 (B)(1)(iii)(C); and
- (3) that such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other Benefits or employee Benefits plan of the Group.

- c. The Group hereby agrees to abide by the Company's acknowledgement and Authorization policies with regards to the exchange of PHI in an electronic format. For example, if the Company provides data to the Group on a compact disc, the Company may require acknowledgement that the data was received by the Group and the name of the Group representative who received the data.

J. U.S. Economic Sanctions Laws Compliance

The Group hereby agrees to comply fully with all applicable economic sanctions and export control laws and regulations, including those regulations maintained by the U.S. Treasury Department's Office of Foreign Assets Control (OFAC). The Group understands that Blue Cross and Blue Shield of Louisiana does not authorize extending coverage to any person to whom the provision of such coverage would be receiving insurance coverage under this or other Blue Cross and Blue Shield of Louisiana Policies, including Subscribers and their covered Dependents, against all relevant U.S. Government lists of persons subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to provide coverage to any person.

The Group agrees that its acceptance of coverage constitutes a representation to Blue Cross and Blue Shield of Louisiana that all applicable laws and regulations have been complied with and that coverage is not being provided to any denied person.

Any extension of coverage in breach of the foregoing shall constitute cause for immediate termination of this Benefit Plan, and denial of Benefits for any Claims made under that coverage, and shall entitle Blue Cross and Blue Shield of Louisiana to indemnification from the Group for any cost, loss, damage, liability, or expense incurred by Blue Cross and Blue Shield of Louisiana as a result thereof. This provision shall survive termination or cancellation of this Benefit Plan.

LLHIGA NOTICE

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association, or LLHIGA. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage. Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer. The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Drawer 44126
Baton Rouge, Louisiana 70804

LA Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

(over)

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association, if:

- (1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- (2) the insurer was not authorized to do business in this state;
- (3) their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- (1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- (2) any policy of reinsurance (unless an assumption certificate was issued);
- (3) interest rate yields that exceed an average rate;
- (4) dividends;
- (5) credits given in connection with the administration of a policy by a group contract holder;
- (6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- (7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered,
- (8) an obligation that does not arise under the express written terms of the policy or contract issued by the contract owner or policy owner, including without limitations, any claims based upon marketing materials, side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements; misrepresentations of or regarding policy benefits; extra-contractual claims; or claims for penalties or consequences of incidental damages;
- (9) a policy or contract providing any hospital, medical, prescription drug or other healthcare benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly referred to as "Medicare Part C coverage" and "Medicare Part D coverage" any regulations issued pursuant to those parts.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall \$500,000 limit, the Association will not pay more than \$300,000 in life insurance death benefits, no more than \$100,000 in net cash surrender values, \$500,000 in health insurance benefits, \$250,000 in present value of annuities, not to exceed \$100,000 in net cash surrender values- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.