BLUE CROSS AND BLUE SHIELD OF LOUISIANA

P. O. Box 98044

Baton Rouge, Louisiana 70898-9044

Has issued this

HIGH DEDUCTIBLE MEDICAL BENEFIT PLAN

No.: 78K22ERC

To: Vermilion Parish School Board

Vermilion Parish School Board (Referred to as "Group"), as of January 1, 2018, ("Benefit Plan Date") agrees to provide Benefits as specified for eligible Plan Participants of the Group. A word used in the masculine gender applies also in the feminine gender, except where this Benefit Plan states otherwise.

Vermilion Parish School Board (the Group) is the Plan Sponsor of this Benefit Plan. Blue Cross and Blue Shield of Louisiana is the Claims Administrator of this Benefit Plan.

Blue Cross and Blue Shield of Louisiana provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims liability. In Witness Whereof, both the Claims Administrator and the Plan Sponsor have signed this Benefit Plan through the respective authorized officers.

Vermilion Parish School Board
Plan Sponsor

Group Executive: _____

Title: _____

Date: _____

Blue Cross and Blue Shield of Louisiana,
Claims Administrator

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

VERMILION PARISH SCHOOL BOARD
HIGH DEDUCTIBLE MEDICAL BENEFIT PLAN

NOTICES

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

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

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

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

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

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

VERMILION PARISH SCHOOL BOARD
HIGH DEDUCTIBLE MEDICAL BENEFIT PLAN
TABLE OF CONTENTS

ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE 6
A. Facts About This High Deductible Health Plan (HDHP) 6
B. Claims Administrator's Provider Network 6
C. Receiving Care Outside the Preferred Network 7
D. Obtaining Emergency and Non-Emergency Care Outside Louisiana and Around the World 7
E. Authorizations 8
F. How the Plan Determines What is Paid for Covered Services 8
G. Sample Illustration of Plan Participant Costs When Using a Non-Participating Hospital 9
H. When a Plan Participant Purchases Covered Prescription Drugs 10
I. When a Plan Participant Receives Mental Health or Substance Use Disorder Benefits 10
J. Assignment of Benefits 10
K. Plan Participant Incentives and Value-Added Services 10
L. Health Management and Wellness Tools and Resources 11
M. Customer Service E-Mail Address 11

ARTICLE II. DEFINITIONS 12

ARTICLE III. SCHEDULE OF ELIGIBILITY 27

ARTICLE IV. BENEFITS 32
A. Benefit Categories 32
B. Deductibles and Coinsurance 32
C. Out-of-Pocket Amount 33

ARTICLE V. HOSPITAL BENEFITS 33
A. Inpatient Bed, Board and General Nursing Service 34
B. Other Hospital Services (Inpatient and Outpatient) 34
C. Pre-Admission Testing Benefits 34

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS 34
A. Surgical Services 34
B. Inpatient Medical Services 36
C. Outpatient Medical and Surgical Services 36
D. Expanded Medical and Surgical Benefits 36

ARTICLE VII. PRESCRIPTION DRUG BENEFITS 37

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE 39

ARTICLE IX. MENTAL HEALTH BENEFITS 46

ARTICLE X. SUBSTANCE USE DISORDER BENEFITS 46

ARTICLE XI. ORGAN, TISSUE, AND BONE MARROW TRANSPLANT BENEFITS 46
A. Acquisition Expenses 46
B. Organ, Tissue and Bone Marrow Transplant Benefits 47
C. Solid Human Organ Transplants 47
D. Tissue Transplant Procedures (Autologous and Allogeneic) 47
E. Bone Marrow Transplants 48

ARTICLE XII. PREGNANCY CARE AND NEWBORN CARE BENEFITS 48
A. Pregnancy Care 48
B. Care for Newborn when Covered at birth as a Dependent 48
C. Statement of Rights under the Newborns' and Mothers' Health Protection Act 49

ARTICLE XIII. REHABILITATIVE / HABILITATIVE CARE BENEFITS 49
A. Occupational Therapy 50
B. Physical Therapy 50
C. Speech/Language Pathology Therapy 50
D. Chiropractic Services 51

ARTICLE XIV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT 51
A. Accidental Injury Benefits 51
B. Ambulance Service Benefits 51
C. Attention Deficit/Hyperactivity Disorder 52
D. Bone Mass Measurement 53
E. Breast Reconstructive Surgery Services 53
F. Cleft Lip and Cleft Palate Services 53
G. Clinical Trial Participation 54
H. Dental Services for Head and Neck Cancer Patients 55
I. Diabetes Education and Training for Self-Management 55
J. Dietitian Visits 56
K. Disposable Medical Equipment and Supplies 56
L. Durable Medical Equipment, Orthotic Devices, Prosthetic Appliances, and Devices 56
M. Hearing Aid Benefits 58
N. Home Health Care Benefits 58
O. Hospice Benefits 58
P. Permanent Sterilization Procedures and Contraceptive Devices 59
Q. Prescription Drugs 59
R. Routine Vision Care 59
S. Sleep Studies 59
T. Telehealth Services 59
U. X-rays, Lab Tests, Machine Tests, and High-Tech Imaging 59

ARTICLE XV. CARE MANAGEMENT 60
A. Selection of Provider, Penalties for Failure to Obtain Authorization, and Authorization of Admissions, Outpatient Services and Other Covered Services and Supplies 60
B. Disease Management 63
C. Case Management 63
D. Alternative Benefits 64

ARTICLE XVI. LIMITATIONS AND EXCLUSIONS 65

ARTICLE XVII. CONTINUATION OF COVERAGE RIGHTS 71
A. Leave of Absence 71
B. Surviving Spouse/Dependents Continuation 72
C. Over-Age Dependents 73
D. Military Leave 73
E. COBRA Continuation 73

ARTICLE XVIII. COORDINATION OF BENEFITS 77
A. Applicability 77
B. Definitions *(Applicable only to this Article of this Benefit Plan)* 77
C. Order of Benefit Determination Rules 80
D. When This Plan is Secondary 83
E. Right to Receive and Release Needed Information 83
F. Facility of Payment 83
G. Right of Recovery 83

ARTICLE XIX. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS 84
A. The Benefit Plan 84
B. Amending and Terminating the Benefit Plan 84
C. Identification Cards and Benefit Plans 85
D. Benefits Which Plan Participants are Entitled 85

E. Termination of a Plan Participant's Coverage 85
F. Filing Claims 85
G. Applicable Law 86
H. Legal Action 86
I. Release of Information 86
J. Assignment 86
K. Plan Participant/Provider Relationship 86
L. This Benefit Plan and Medicare 87
M. Notice 87
N. Job-Related Injury or Illness 87
O. Subrogation 88
P. Right of Recovery 88
Q. Coverage in a Department of Veterans Affairs or Military Hospital 88
R. Liability of Plan Affiliates 89
S. Out-of-Area Services 89
T. Certificates of Creditable Coverage 91
U. Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage 91
V. Continued Coverage During a Leave of Absence 92
W. Compliance with HIPAA Privacy Standards 93
X. Compliance with HIPAA Electronic Security Standards 94

ARTICLE XX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES 95

ARTICLE XXI. CARE WHILE TRAVELING, MAKING PLAN CHANGES AND FILING CLAIMS 99
A. How to Obtain Care While Traveling 100
B. Adding or Changing the Plan Participant's Family Members on the Plan 100
C. How to File Claims for Benefits 100
D. Filing Specific Claims 101
E. If Plan Participant Has a Question about His Claim 102

ARTICLE XXII. RESPONSIBILITIES OF PLAN ADMINISTRATOR 103
A. Plan Administrator 103
B. Duties of the Plan Administrator 103
C. Plan Administrator Compensation 103
D. Fiduciary 104
E. The Claims Administrator is not a Fiduciary 104

ARTICLE XXIII. GENERAL PLAN INFORMATION 105

ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

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

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

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

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

A. Facts About This High Deductible Health Plan (HDHP)

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

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

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

B. Claims Administrator's Provider Network

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

The Preferred Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with the Claims Administrator to participate in the Blue Cross and Blue Shield of Louisiana Preferred Care PPO Network and render services to the Plan Participants. These Providers are called "Preferred Providers" or Network Providers.

To obtain the highest level of Benefits available, the Plan Participant should verify that the Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Provider before services are rendered. Plan Participants may review a current paper Provider directory, check on-line at **www.bcbsla.com**, or contact the Claims Administrator's customer service department at the number listed on their ID card.

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

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

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

C. Receiving Care Outside the Preferred Network

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

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

It is recommended that the Plan Participant ask Non-Network Providers to explain their billed charges, before care is received outside the Network. You should review the sample illustration below prior to obtaining care outside the Network. Prior to obtaining care outside the Network, You should review the section titled "Sample Illustration of Plan Participant Costs When Using a Non-Participating Hospital."

D. Obtaining Emergency and Non-Emergency Care Outside Louisiana and Around the World

Plan Participants have access to Emergency and Non-Emergency care outside Louisiana and around the world. The Plan Participant's ID card offers convenient access to Covered Services through Blue Cross and Blue Shield Providers throughout the United States and in more than 200 countries worldwide.

In the United States:
Plan Participants receive In-Network Benefits when Emergency and Non-Emergency Covered Services are provided by PPO Providers in other states. If Plan Participants do not go to a PPO Provider, Out-of-Network Benefits will apply. Covered Emergency Services are paid In-Network regardless of Provider.

Outside the United States:
Plan Participants receive In-Network Benefits when covered Emergency and Non-Emergency Services are provided by a Blue Cross Blue Shield Global Core Provider across the world. If Plan Participants do not go to a Blue Cross Blue Shield Global Core Provider, Out-of-Network Benefits will apply.

Covered Emergency Services are paid In-Network regardless of Provider.

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 (for care within the United States), or for information on Blue Cross Blue Shield Global Core doctors and Hospitals (for care outside the United States). Provider information is also available at **www.bcbs.com**.

3. Use a designated PPO Provider or Blue Cross Blue Shield Global Core Provider to receive the highest level of Benefits.

4. Present a Plan Participant ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.

5. The Plan Participant must obtain any required Authorizations from the Claims Administrator.

E. Authorizations

Some services and supplies require Authorization from the Claims Administrator before services are obtained. Your Schedule of Benefits lists the services, supplies, and Prescription Drugs that require this advance Authorization. See the Care Management Article of this Benefit Plan for additional information regarding Authorization requirements.

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

F. How the Plan Determines What is Paid for Covered Services

1. When a Plan Participant Uses Preferred Providers

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

2. When a Plan Participant Uses Participating Providers

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

3. When a Plan Participant Uses Non-Participating Providers

   Non-Participating Providers are Providers who have not signed any contract with the Claims Administrator or any other Blue Cross and Blue Shield plan to participate in any Blue Cross and Blue Shield Network. These Providers are not in the Claims Administrator's Networks. The Claims Administrator has no fee arrangements with them.

   The Claims Administrator establishes an Allowable Charge for Covered Services provided by Non-Participating Providers. The Allowable Charge will be the lesser of the following:

1. An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;

2. an amount We establish as the Allowable Charge; or

3. the Provider's billed charge. You will receive a lower level of Benefit because You did not go to a Preferred Provider.

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

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

G. Sample Illustration of Plan Participant Costs When Using a Non-Participating Hospital

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

EXAMPLE: A Plan Participant has a PPO plan with a $500 Deductible Amount. The Plan Participant has 80/20 Coinsurance when he receives Covered Services from Hospitals in the Preferred Network and 60/40 Coinsurance when he receives Covered Services from Hospitals that are not in the Preferred Network. Assume the Plan Participant goes to the Hospital, has previously met his Deductible, and has obtained the necessary Authorizations prior to receiving a non-emergency service. The Provider's billed charge for the Covered Services is $12,000. The Claims Administrator negotiated an Allowable Charge of $2,500 with its Preferred Network Hospitals to render this service. The Allowable Charge of Participating Providers is $3,000 to render this service. There is no negotiated rate with the Non-Participating Hospital.

The Plan Participant receives Covered Services from:	**Preferred Provider Hospital**	**Participating Provider Hospital**	**Non-Participating Provider Hospital**
Provider's Bill:	$12,000	$12,000	$12,000
Allowable Charge:	$2,500	$3,000	$2,500
The Plan pays:	$2,000 $2,500 Allowable Charge x 80% Coinsurance = $2,000	$1,800 $3,000 Allowable Charge x 60% Coinsurance = $1,800	$1,500 $2,500 Allowable Charge x 60% Coinsurance - $1,500
Plan Participant pays:	$500 20% Coinsurance x $2500 Allowable Charge =$500	$1,200 40% Coinsurance x $3,000 Allowable Charge - $1,200	$1,000 $2,500 Allowable Charge x 40% Coinsurance = $1000
Is Plan Participant billed up to the Provider's billed charge?	NO	NO	YES - $9,500 for a total of:

Total Plan Participant Pays	$500	$1,200	$10,500

H. When a Plan Participant Purchases Covered Prescription Drugs

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

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

I. When a Plan Participant Receives Mental Health or Substance Use Disorder Benefits

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

J. Assignment of Benefits

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

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

K. Plan Participant Incentives and Value-Added Services

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

L. Health Management and Wellness Tools and Resources

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

M. Customer Service E-Mail Address

The Claims Administrator has consolidated its customer service e-mails into a single, easy-to-read address: **help@bcbsla.com**. Plan Participants who need to contact the Claims Administrator may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit **www.bcbsla.com** and click on "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. If Benefits are available for the treatment of a particular injury, Benefits will be provided for an injury that results from an act of domestic violence or a medical condition.

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

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

A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or Investigational;

B. the Plan Participant's eligibility to participate in the Benefit Plan;

C. any prospective or retrospective review determination; or

D. a Rescission of Coverage.

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

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

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

Allowable Charge –

A. For Preferred Providers and Participating Providers - The lesser of the billed charge or the amount established by the Claims Administrator or negotiated as the maximum amount allowed for services from these Providers covered under the terms of this Benefit Plan.

B. For Non-Participating Providers – The lesser of:

    1. An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;

    2. an amount We establish as the Allowable Charge; or

    3. the Provider's billed charge.

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

Ambulance Service – Medically Necessary transportation by 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.

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

Appeal – A written request from a Plan Participant or authorized representative to change an Adverse Benefit Determination made by the Claims Administrator.

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

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

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

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

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

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

Benefit Plan – The program established by the Group to provide Benefits for eligible Plan Participants.

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

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

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

Care Coordination – Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Plan Participant's healthcare needs across the continuum of care.

Care Coordinator Fee – A fixed amount paid by Blue Cross and Blue Shield of Louisiana to Providers periodically for Care Coordination under a Value-Based Program.

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

Child or Children – includes:

A. a Child of the Employee/Retiree;

B. a Child of the Employee/Retiree's Spouse;

C. a Child placed for adoption with the Employee/Retiree through an agency adoption;

D. a Child under the court-ordered legal guardianship or in the court-ordered custody of the Employee/Retiree;

E. a grandchild of the Employee/Retiree whose parent is covered under the Plan as a Dependent, or a child for whom the Employee/Retiree has current provisional custody, which grandchild/child has not been adopted by the Employee/Retiree and for whom the Employee/Retiree has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a "Child" as of December 31, 2015.

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

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

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

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

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and its regulations.

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

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

Allowable Charges for Covered Services to determine the Plan Participant's financial responsibility. The Plan's percentage will be applied to the Allowable Charges for Covered Services to determine the 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 Claims Administrator or Provider services.

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

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

Congenital Anomaly – A condition existing at or from birth, which significantly interferes with normal bodily function. For purposes of this Benefit Plan, the Plan will determine what conditions will be covered as Congenital Anomalies. In no event will the term Congenital Anomaly include conditions relating to teeth or structures supporting the teeth, except for Cleft Lip and Cleft Palate Services.

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

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

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 – 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 Claims Administrator determines which services are Custodial Care.

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

A. Spouse: the date of marriage;

B. Child or Children

1. Natural Children – the date of birth;

2. Children placed for adoption with the Employee/Retiree:

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

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

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

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

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

Deductible Amount

A. Individual Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Plan Participant on an Employee Only benefit plan must pay within a Benefit Period before this Benefit Plan starts paying Benefits.

B. Family Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that must be paid by a family within a Benefit Period before this Plan starts paying Benefits. When the Benefit Plan includes more than one (1) covered Plan Participant, the Individual Deductible Amount is not applicable. Only the Family Deductible Amount is applicable. No Benefits are eligible for payment toward Covered Services on any covered Plan Participant until the Family Deductible Amount has been met. Once the Family Deductible Amount is met, this Plan starts paying Benefits for all covered Plan Participants of the family for the remainder of the Benefit Period.

   For purposes of this Benefit Plan, “Family” includes all available classes of coverage, except single Plan Participant or Employee only coverage. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan.

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

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

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

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

Dependent – Any of the following persons who are enrolled for coverage as Dependents by completing appropriate enrollment documents and whose relationship to the Employee/Retiree has been documented. Anyone covered as an Employee/Retiree may not also be covered as a Dependent.

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

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

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

   2. A child for whom the Employee/Retiree has current provisional custody and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which child was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until the provisional custody term ends, the end of the month the child reaches the age of majority, or the child no longer meets the eligibility requirements under this Plan, whichever is earlier;

   3. A Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship/tutorship but who has not been adopted by the Employee/Retiree, from Date Acquired until the custody/guardianship/tutorship order expires or the end of the month the Child reaches the age of majority, whichever is earlier.

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

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

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

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

Emergency – See "Emergency Medical Condition."

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

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

Emergency Medical Services – Any healthcare service provided to evaluate and/or treat an Emergency Medical Condition requiring immediate unscheduled medical care.

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

Employer – Vermilion Parish School Board

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

A. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Member's ability to regain maximum function.

B. In the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

C. Decision not to Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

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

A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function, or a decision not to Authorize continued services for Plan Participants currently in the Emergency room, under observation, or receiving Inpatient care.

B. A denial of coverage based on a determination the recommended or requested healthcare service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Plan Participant's health, including severe pain, potential loss of life, limb or major bodily function.

External Appeal – A request for review by an Independent Review Organization (IRO), to change a final Adverse Benefit Determination rendered on Appeal. External Appeal is available by request from the Plan Participant or his authorized representative for Adverse Benefit Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission of Coverage.

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

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

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

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

Group – Vermilion Parish School Board or other legal entity of Vermilion Parish School Board who is the Plan Administrator and sponsor of this Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

Habilitative Care – Healthcare services and devices that help a patient keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance Marketplace (Marketplace) – An organization operated by the federal government for the State of Louisiana, under Section 1311 of the Patient Protection and Affordable Care Act, to facilitate the purchase of health insurance.

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

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

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

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

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

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

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

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

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

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

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

Intensive Outpatient Programs – Intensive Outpatient Programs are defined as having the capacity for planned, structured, service provision of at least two (2) hours per day and three (3) days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated

multidisciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment.” (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge.)

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

A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, 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.

Medically Necessary (or Medical Necessity) – Healthcare 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.

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychoses, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by La. R.S. 22:1043 (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under seventeen (17) years of age; Rett’s Disorder; and Tourette’s Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric

Association, Washington, D.C. (DSM), including other non-psychotic mental disorders, to be determined by the Plan. The definition of Mental Disorder (Mental Health) shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

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

Negotiated Arrangement ("Negotiated National Account Arrangement") – An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Network Benefits – Benefits for care received from a Network Provider, also referred to as In-Network Benefits.

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

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

Non-Network Benefits – Benefits for care received from Non-Network Providers, also referred to as Out-of-Network Benefits.

Non-Network Provider – A Provider who is not a member of the Claims Administrator's Preferred Care Provider Network or another Blue Cross and Blue Shield Plan PPO Network. Participating Providers and Non-Participating Providers are Non-Network Providers.

Non-Preferred Brand/Generic Drugs – 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.

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

Open Enrollment – A period of time, designated by the Plan, during which an eligible Employee, Retiree and any eligible Dependents may enroll for Benefits under this 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

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

B. Family Out-of-Pocket Amount – The maximum amount, as shown in the Schedule of Benefits, of non-reimbursable expenses (including any applicable Deductible Amount and Coinsurance), which must be paid by a family for Covered Services in one (1) Benefit Period. When the Benefit Plan includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. Only the Family Out-of-Pocket Amount is applicable. For purposes of this Benefit Plan, "Family" includes all available Classes of Coverage, except single Plan Participant or Employee only coverage.

Outpatient – A Plan Participant 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.

Participant Employer – A state entity, school board, or a state political subdivision authorized by law to participate in an Office of Group Benefits health plan.

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

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

Plan – Vermilion Parish School Board's medical Benefits plan for certain Employees of Vermilion Parish School Board and is described in this document.

Plan Administrator – The person or entity designated by the Plan Sponsor to administer this group Plan. If no one is designated, the Plan Sponsor is the Plan Administrator

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

Plan Sponsor – Vermilion Parish School Board, who provides these Benefits on behalf of its eligible Employees, Retirees and their eligible Dependents.

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

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

Pregnancy Care – Treatment or services related to all care prior to delivery, delivery, post-delivery 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 healthcare professional and that carry the federally required product legend stipulating that such drugs may not be dispensed without a prescription, and which are currently approved by the FDA for safety and effectiveness, subject to the Limitations and Exclusions Article.

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

Prescription Drug Formulary – A list of specific Prescription Drugs that are covered under this Benefit Plan.

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

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

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

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

A. Preferred Provider (Preferred Care Provider) – A Provider who has entered into a contract with the Claims Administrator to participate in its Preferred Care PPO Network, as shown in the Schedule of Benefits. This Provider is also referred to as a Network Provider.

B. Participating Provider – A Provider that has a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan for other than a Preferred Care or PPO Provider Network.

C. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan.

Provider Incentive – An additional amount of compensation paid to a healthcare Provider by a payer, based on the Provider's compliance with agreed- upon procedural and/or outcome measures for a particular group or population of covered persons.

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

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

Residential Treatment Center – A twenty-four (24) hour, non-acute care treatment setting for the active treatment of specific impairments of mental health or substance use disorder.

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

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

A. Immediately received a retirement plan distribution from an approved state or state governmental agency defined benefit plan;

B. Was not eligible for participation in such a plan or legally opted not to participate in such a plan, and either

    1. Began employment prior to September 16, 1979, has ten (10) years of continuous service and has reached the age of sixty-five (65); or

    2. Began employment on or after September 16, 1979, has ten (10) years of continuous state service and has reached the age of seventy (70); or

3. Began employment after July 8, 1992, has ten (10) years of continuous state service, has a credit for a minimum of forty (40) quarters in the Social Security system at the time of employment, and has reached the age of sixty-five (65); or

4. Maintained continuous coverage with the Plan as an eligible Dependent until he became eligible to receive a retirement benefit from an approved state governmental agency defined benefit plan as a former state employee.

C. Immediately received a retirement plan distribution from a state approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan shall be responsible for certification of eligibility hereunder to the Plan Administrator.

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

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

A. Inpatient medical care, treatment and skilled nursing care as defined by Medicare and which meets the Medicare requirements for this type of facility;

B. full-time supervision by at least one Physician or Registered Nurse;

C. twenty-four (24) hour nursing service by Registered Nurses or Licensed Practical Nurses; and

D. Utilization review plans for all patients.

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

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Plan) within thirty (30) days of experiencing a HIPPA Special Enrollment Event, including but not limited to losing other certain health coverage under certain circumstances enumerated by Law (unless an longer period is required by applicable Law) or acquiring a new Dependent as a result of marriage, birth, adoption or placement for adoption.

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

A. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.

B. Coordination of care is required prior to drug therapy initiation and/or during therapy.

C. Unique patient compliance and safety monitoring requirements.

D. Unique requirements for handling, shipping and storage.

E. Restricted access or limited distribution.

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

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

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

Surgery

A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic exams, incisional and excisional biopsies and other invasive procedures;

B. the correction of fractures and dislocations;

C. Pregnancy Care to include vaginal deliveries and caesarean sections

D. usual and related pre-operative and post-operative care; or

E. other procedures as defined and approved by the Plan.

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

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

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

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

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

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

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

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. Routine examinations ordered after the infant reaches 24 months will be subject to the Routine Wellness Physical Exam Benefit.

ARTICLE III. SCHEDULE OF ELIGIBILITY

The Plan Administrator has full discretionary authority to determine eligibility for coverage / Benefits and to construe the terms of this Plan. A Temporary Employee does not meet the eligibility requirements under this Benefit Plan, unless such Employee is determined to be an FTE.

A. Persons to be Covered

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

1. Employees

a. A full-time Employee as defined by the Employer and any Full Time Equivalent, both as determined in accordance with applicable state and federal law.

b. Spouse

If a covered Spouse is eligible for coverage as an Employee and chooses at a later date to be covered separately, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase the Benefits.

c. Re-enrollment for Health and/or Life Benefits

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

d. Board and Commission Members

Members of school boards, state boards, or commissions, defined by the Group as full-time Employees, are eligible to participate in this Benefit Plan.

2. Retirees

A person meeting the definition of "Retiree" shall be eligible for coverage under this Benefit Plan. Retirees may not be covered as an Employee. Retirees may not be covered as an Employee.

3. Documented Dependents

a. A documented Dependent of an eligible Employee or Retiree will be eligible for Dependent coverage on the latest of the following dates:

(1) The date the Employee or Retiree becomes eligible, or

(2) The Date Acquired for Employee’s or Retiree’s Dependents.

b. The following written proof of relationship to the Employee or Retiree must be presented to the Plan Administrator, or representative designated by the Plan Administrator, for inspection and copying:

(1) Spouse – A certified copy of the certificate of marriage, indicating date and place of marriage.

(2) Child or Children:

(a) Naturally or legally adopted Child or Children of Plan Participant – Certified copy of birth certificate listing Plan Participant as parent or certified copy of legal acknowledgment of paternity signed by the Plan Participant or certified copy of adoption decree naming Plan Participant as adoptive parent.

(b) Stepchild – Certified copy of certificate of marriage to Spouse and birth certificate or adoption decree listing Spouse as natural or adoptive parent.

(c) Child placed with Your family for adoption by agency adoption or irrevocable act of voluntary surrender for private adoption – Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender.

(d) Child for whom You have been granted court-ordered legal guardianship or court-ordered custody – Certified copy of the signed court order granting legal guardianship or custody.

(e) Child age 26 or older who is incapable of self-sustaining employment and who was covered prior to and upon attainment of age 26 – Documentation as described in A.3.b.(2)(a-d) above, together with an application for continued coverage and supporting medical documentation which must be received by the Plan Administrator prior to the child's attainment of age 26, as well as additional medical documentation of child's continuing condition periodically upon request by the Plan Administrator.

(f) Medical Child Support Orders

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

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

ii. Provides for healthcare coverage for that Dependent Child;

iii. Is made under state domestic relations law (including a community property law);

iv. Relates to Benefits under the Plan; and

v. Is "qualified" in that it meets the technical requirements of applicable state law.

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

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

(3) Such other written proof of relationship to the Employee/Retiree deemed sufficient by the Plan Administrator.

B. Enrollment for Coverage

An enrollment form must be completed within thirty (30) days of eligibility for coverage.

C. Available Classes of Coverage

1. Employee Only coverage means coverage for the Employee only.

2. Employee and Spouse coverage means coverage for the Employee and his/her Spouse.

3. Employee and Child(ren) coverage means coverage for the Employee and one or more Dependents.

4. Family coverage means coverage for the Employee, his/her Spouse, and one or more Dependents.

D. Change of Classification

1. Adding or Deleting Dependents

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

2. Change in Coverage

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

3. Notification of Change

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

E. Effective Date of Coverage

1. New Employee, Transferring Employee and FTE

Coverage for an Employee who completes the applicable enrollment form and agrees to make the required Employee contribution is effective as follows:

a. For new full-time Employees, if employment begins on the first day of the month, coverage is effective the first day of the following month (for example, if hired on July 1st, coverage will begin on August 1st).

b. For new full-time Employees, if employment begins on or after the second day of the month, coverage is effective the first day of the second month following employment (for example, if hired on July 15th, coverage will begin on September 1st).

c. Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If completed after thirty (30) days following the date of employment, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

d. An Employee who transfers employment to this Employer from another Participant Employer must complete a transfer form within thirty (30) days following the date of transfer in order to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

e. An Employee who is determined to be an FTE will be allowed to enroll in this Benefit Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth month of employment for those Employees determined to be FTEs during their initial measurement period.

2. Retiree

Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree agrees to make and is making the required contributions. For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. For example, if date of retirement is July 15, Retiree coverage will begin August 1; if date of retirement is August 1, Retiree coverage will begin September 1.

3. Documented Dependents of Employees

Coverage will be effective on the date of marriage for new Spouses, the date of birth for newborn children, or the Date Acquired for other classifications of Dependents.

4. Documented Dependents of Retirees

Coverage will be effective on the first day of the month following the date of retirement if the Retiree and his Dependents were covered immediately prior to retirement. Coverage for Dependents of Retirees first becoming eligible for Dependent Coverage following the date of retirement will be effective on the Date Acquired.

F. HIPAA Special Enrollment Events

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

1. Retirees Special Enrollment

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

a. Retirement began on or after July 1, 1997;

b. The Retiree can document that Creditable Coverage was in force at the time of the election not to participate or continue participation in the Plan;

c. The Retiree can demonstrate that Creditable Coverage was maintained continuously from the time of the election until the time of requesting special enrollment;

d. The Retiree has exhausted all COBRA and/or other continuation rights and has made a formal request to enroll within thirty (30) days of the loss of other coverage; and

e. The Retiree has lost eligibility to maintain other coverage through no fault of his own and has no other Creditable Coverage in effect.

2. Effective Date of Coverage for Special Enrollees

The Effective Date of Coverage for Special Enrollees who timely enroll shall be:

a. For loss of other coverage or marriage, the first of the month following the date the Plan Administrator receives all required forms for enrollment;

b. For birth of a Dependent, the date of birth;

c. For adoption, the date of adoption or placement for adoption.

d. Medicare Advantage Option for Retirees

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

(1) during the month of November, for coverage effective January 1; or

(2) during the next Annual Enrollment, for coverage effective at the beginning of the next Plan Year.

Retirees who elect to participate in a Medicare Advantage Plan not sponsored by the Group will not be allowed to reenroll in this Plan upon withdrawal from or termination of coverage in the Medicare Advantage Plan. If the Group does not sponsor a Medicare Advantage Plan when the eligible Retiree elects to participate in a Medicare Advantage Plan, this restriction will not apply should the Retiree later wish to reenroll in this Plan.

e. TRICARE for Life Option for Military Retirees

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

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. Benefit Categories

1. Network Benefits (In-Network) – Benefits for Covered Services received from a Preferred Care Provider. When a Plan Participant receives care from a Network Provider, he will receive the highest level of Benefits on this Plan.

2. Non-Network Benefits (Out-of-Network) – Benefits for Covered Services received from a Provider who is not contracted with the Claims Administrator as a Preferred Care Provider. Participating Providers and Non-Participating Providers are not contracted with Our Preferred Care PPO Network. When a Plan Participant receives care from a Non-Network Provider, he will receive a lower level of Benefits on this Plan.

B. Deductibles and Coinsurance

1. Subject to the Deductible Amounts shown in the Schedule of Benefits, the maximum limitations hereinafter provided, and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in accordance with the Coinsurance percentage shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period. The following deductibles may apply to Benefits provided by this Plan. Deductibles will accrue to the Out-of-Pocket Amount.

    a. Individual Benefit Period Deductible Amount: The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that the Plan Participant must pay within a Benefit Period before the Plan starts paying Benefits. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits.

    b. Family Benefit Period Deductible Amount: For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Benefit Period Deductible Amount. Once the family has met its Family Deductible Amount, this Benefit Plan starts paying Benefits for all covered members of the family, even if each covered family member has not met his individual Benefit Period Deductible. No Plan Participant may contribute more than his Benefit Period Deductible Amount to satisfy the maximum amount required of a family.

    c. Prescription Drug Deductible Amount: The accumulated dollar amount, shown in the Schedule of Benefits, which each Plan Participant or family must pay within a Benefit Period prior to paying a Prescription Drug Coinsurance percentage. The Prescription Drug Deductible Amount DOES accrue to the Individual Benefit Period Deductible Amount or the Family Benefit Period Deductible Amount.

2. The Coinsurance percentage is shown on the Schedule of Benefits for a Covered Service. The Plan Participant must first pay any applicable Deductible Amount before the Coinsurance percentage. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in the Coinsurance percentages shown in the Schedule of Benefits toward Allowable Charges for Covered Services. The actual payment to a Provider or payment to the Plan Participant satisfies the Plan Sponsor's obligation to provide Benefits under this Benefit Plan.

3. This Benefit Plan does not provide a fourth-quarter Deductible carryover for charges incurred for Covered Services incurred during the months of October, November and December.

4. The Claims Administrator will apply the Plan Participant's Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from

another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by the Claims Administrator. The Claims Administrator's system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays his Deductible Amount, he is entitled to receive a refund from the Provider to whom the overpayment was made.

5. Under certain circumstances, if the Plan pays a healthcare provider amounts that are the Plan Participant's responsibility such as Deductibles or Coinsurance, the Plan may collect such amounts directly from You.

C. Out-of-Pocket Amount

1. After the Plan Participant has met the Out-of- Pocket Amount, as shown in the Schedule of Benefits, the Benefit Plan will pay one hundred percent (100%) of the Plan Participant's Coinsurance amount which is based on the Allowable Charge.

2. If this Benefit Plan includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable and only the Family Out-of-Pocket Amount applies. After the Family Out-of-Pocket Amount has been met, as shown in the Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Plan Participant's Coinsurance amount which is based on the Allowable Charge for all covered family members.

3. The following accrue to the Out-of-Pocket Amount of this Benefit Plan:

   a. Deductible; and

   b. Coinsurance

4. The following do not accrue to the Out-of-Pocket Amount of this Benefit Plan:

   a. any charges in excess of the Allowable Charge;

   b. any penalties the Plan Participant or Provider must pay;

   c. charges for non-covered services; and

   d. any other amounts paid by the Plan Participant other than Deductibles and Coinsurance.

ARTICLE V. HOSPITAL BENEFITS

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

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.

2. In a Special Care Unit for a critically ill Plan Participant requiring an intensive level of care.

3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us. A maximum number of days per Benefit Period may apply if shown in the Schedule of Benefits.

4. In a Residential Treatment Center for Plan Participants with a Mental Disorder or substance use disorder impairment.

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; and

8. Psychological testing ordered by the attending Physician and performed by a Hospital employee.

C. Pre-Admission Testing Benefits

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

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

Benefits for the following medical and surgical services are available and may require Authorization. See the Schedule of Benefits and the Care Management Article to determine which services require Authorization. A Plan Participant must pay any applicable Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.

A. Surgical Services

1. Surgery

   a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by the Plan and is that period of time which is appropriate as routine care for the particular surgical procedure.

   b. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

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

   a. Primary Procedure

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

      (2) Benefits for the primary procedure will be based on the Allowable Charge.

   b. Secondary Procedure(s)

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

   c. Incidental Procedure

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

      (2) The Allowable Charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

   d. Unbundled Procedure(s)

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

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

   e. Mutually Exclusive Procedure(s)

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

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

3. Assistant Surgeon

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

4. Anesthesia

   a. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined the Plan and approved by the Claims Administrator. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.

   b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless the Claims Administrator determines otherwise.

   c. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

5. Second Surgical Opinion

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

B. Inpatient Medical Services

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

1. Inpatient medical care visits;

2. Concurrent Care; and

3. Consultation (as defined in this Benefit Plan).

C. Outpatient Medical and Surgical Services

1. Home, office, and other Outpatient visits for examination, diagnosis, and treatment of an illness or injury. Benefits for Outpatient medical services do not include separate payments for routine pre-operative and post-operative medical visits for Surgery or Pregnancy Care.

2. Consultation (as defined in this Benefit Plan);

3. Diagnostic Services;

4. Services of an Ambulatory Surgical Center; and

5. Services of an Urgent Care Center.

D. Expanded Medical and Surgical Benefits

The Plan may provide coverage to Plan Participants above and beyond the Benefits stated in this Benefit Plan when, in Plan Sponsor's discretion, it determines that a disaster, state of emergency or other event may disrupt or seriously threaten to disrupt healthcare or other services provided for under this Benefit Plan.

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

A. Coverage is available for Prescription Drugs as shown in the Schedule of Benefits. The Prescription Drugs must be dispensed on or after the Plan Participant's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that the Claims Administrator determines and only those Prescription Drugs that the Claims Administrator determines 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. The Plan Participant can view the Claim Administrator's Blue Selections Rx Plan Participant Guide at **www.bcbsla.com** or request a copy by mail by calling the Claim Administrator's pharmacy benefit manager at the telephone number indicated on the Plan Participant's ID card.

C. Necessary insulin syringes and test strips are covered under the Prescription Drug Benefit.

D. The Claims Administrator's Prescription Drug Utilization Management Program features a set of closely aligned programs that are designed to promote Plan Participant safety, appropriate and cost effective use of medications, and monitor healthcare quality. Examples of these programs include:

1. Prior Authorization – As part of the Prescription Drug Utilization Management program, Plan Participants and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing at **www.bcbsla.com** or by calling the customer-service telephone number on the Plan Participant's ID card. If the Prescription Drug requires prior Authorization, the Plan Participant's Physician must call the medical Authorization telephone number on the Plan Participant's ID card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.

2. Safety checks – Before the Plan Participant's prescription is filled, the Claims Administrator's pharmacy benefit manager or the Claims Administrator performs quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g. refill prior to seventy-five (75%) day supply used).

3. Quantity Per Dispensing Limits/Allowances – Prescription Drugs selected by the Claims Administrator are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity per Dispensing Limits/Allowances are based on the following:

   a) the manufacturer's recommended dosage and duration of therapy;

   b) common usage for episodic or intermittent treatment;

   c) FDA-approved recommendations and/or clinical studies; or

   d) as determined by the Plan.

4. Step Therapy – Certain drugs and/or drug classes are subject to Step Therapy. In some cases, the Plan may require the Plan Participant to first try one or more Prescription Drugs to treat a medical condition before the Plan will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Plan Participant's medical condition, the Plan may require the Plan Participant's Physician to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Plan will cover a prescription written for Drug B. However, if Your physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the drug.

E. Some pharmacies have contracted with the Claims Administrator or with the Claims Administrator's pharmacy benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are “Participating Pharmacies.” Benefits are based on the Allowable Charge as determined by the Claims Administrator. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base the Plan’s payment for the Plan Participant’s covered Prescription Drugs.

F. When a Plan Participant purchases covered Prescription Drugs from a pharmacy that has not contracted with the Claims Administrator or with the Claims Administrator’s pharmacy benefit manager 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.

G. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Plan Participant should submit Claims on the Claims Administrator’s Prescription Drug Claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Plan Participant should contact the Claims Administrator or the Claims Administrator’s pharmacy benefit manager at the telephone number indicated on His ID card.

H. As part of the Claims Administrator’s administration of Prescription Drug Benefits, the Claims Administrator may disclose information about the Plan Participant’s Prescription Drug utilization, including the names of the Plan Participant’s prescribing Physicians, to any treating Physicians or dispensing pharmacies.

I. The Plan shall receive one hundred percent (100%) of savings realized by the Claims Administrator under their cost containment programs that are attributable to Claims under the Plan, through billing of actual payments for Claims made under these programs.

J. This Benefit Plan uses an open Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under the Plan. With an open formulary, new Prescription Drugs are automatically included to the list when drug manufacturers release these new drugs for sale. Placement of Prescription Drugs on a drug tier may be based on a drug's quality, safety, clinical efficacy, available alternatives, and cost. The Claims Administrator reviews the Prescription Drug Formulary at least once per year.

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

K. Prescription Drug Benefits

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

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

   2. The participating pharmacy may collect one hundred percent (100%) of the discounted cost of the drug at the point of sale if the Plan Participant has not met his Deductible. If the Plan Participant has met his Deductible, he will pay the applicable Coinsurance percentage shown in the Schedule of Benefits.

3. The participating pharmacy will electronically submit the Claim for the Plan Participant. The Deductible Amount and Coinsurance will be applied and any applicable reimbursement will be sent to the Plan Participant.

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

Preventive and Wellness Care services are covered unless otherwise noted in the service description. New services are also covered when required by law.

This Benefit Plan covers services recommended by the United States Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. The list of Covered Services changes from time to time. New Preventive or Wellness Care services usually become covered within one year from the date recommended. To check the current list of recommended services, visit the United States Department of Health and Human Services' website at: **https://www.healthcare.gov/preventive-care-benefits/** or contact Our customer service department at the telephone number on Your ID card.

A. Preventive or Wellness Care Benefits

1. Network Benefits – Covered in full, no Deductible or Coinsurance applied.

2. Non-Network Benefits – Covered subject to the Coinsurance percentage shown in the Schedule of Benefits. The Deductible is waived for Preventive or Wellness Care.

B. The following Preventive or Wellness Care services are available to a Plan Participant.

PREVENTIVE or WELLNESS CARE SERVICES	AGE / CRITERIA
EXAMINATIONS AND TESTING – ALL ADULTS	
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels). Limit of one (1) per Benefit Period. High-Tech Imaging services such as an MRI, MRA, CT scan, PET scan, and nuclear cardiology are not covered under this Preventive or Wellness Benefit but may be covered under contract Benefits.	All Ages
Colorectal Cancer Screening – • Fecal immunochemical test for blood (FIT): One (1) per Benefit Period. • Flexible sigmoidoscopy: One (1) every five (5) years. • Colonoscopy: One (1) every five (5) years. • Physician prescribed colonoscopy preparation medications: Limit of two (2) prescriptions for selected generic drugs. • Cologuard DNA Testing: One (1) every three (3) years. • Computed Tomographic (CT) Colonography: One (1) every five (5) years. Any additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Services deemed Investigational are not covered.	All Ages All Ages All Ages All Ages All Ages All Ages
IMMUNIZATIONS – ALL ADULTS	
Immunizations recommended by Physician	All Ages
Seasonal Flu and H1N1 Immunizations	All Ages
SCREENINGS, COUNSELING AND SUPPLEMENTS – ALL ADULTS	
Alcohol Misuse Screening and Counseling	Adults: Ages 18 and older
Aspirin Counseling for Prevention of Cardiovascular Disease and Colorectal Cancer	Men: Ages 50 – 59 Women: Ages 50 – 59

Blood Pressure Screening • Office Blood Pressure Monitoring • Ambulatory Blood Pressure Monitoring (ABPM) • Home Blood Pressure Monitoring (HBPM) Limit of one (1) per Benefit Period for services listed above. • Annual Blood Pressure Screening	Ages 18 and older 40 years or older and those at increased risk for high blood pressure
Cardiovascular Disease Counseling	Adults who are overweight or obese and have additional risk factors
Cholesterol Screening	Men: Ages 20 – 35 if at risk; or 35 and older Women: Ages 20 – 45 if at risk; or 45 and older
Depression Screening	All Ages
Diet Counseling	Adults with hyperlipidemia and other risk factors
Fall Prevention Intervention	Ages 65 and older
Generic low-to-moderate dose statins	40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
Generic/Single Source Brand Prescription and Over-the-Counter Smoking Cessation Products: Limit 180 days per calendar year	Ages 18 and older
Generic Vitamin D (up to 800 IU)	Ages 65 and older
Hepatitis B Screening	High risk adults
Hepatitis C Screening	High risk adults and **adults born between 1945 and 1965**
HIV Screening and Counseling	Ages 15 – 65; younger or older if at increased risk
Lung Cancer Screening	Ages 55 – 80 (per guidelines for smoking history)
Obesity Screening and Counseling	Adults with a body mass index higher than 30 kg/m^2

Sexually Transmitted Infection Counseling	Sexually active adults at increased risk
Skin Cancer Screening	Ages 10 – 24
Syphilis Screening	Adults at increased risk
Latent tuberculosis infection (LTBI) screening	Asymptomatic adults 18 years and older at increased risk for infection
Tobacco Use Screening and Counseling	All ages
Type 2 Diabetes Screening	Asymptomatic adults with blood pressure higher than 135/80 mmHg
COVERED SERVICES FOR FEMALES	
Contraceptives – All Food and Drug Administration approved methods, as prescribed by a Physician	Women with reproductive capacity
BRCA Genetic Testing – Screening and Counseling	Women with family history of risk (per guidelines)
Breast Cancer Chemoprevention Counseling	Women at risk for breast cancer
Chlamydia Infection Screening	Women ages 24 and younger who are sexually active; older if at increased risk
Generic Folic Acid Supplements (Prescription Drug Benefit) – 0.4mg to 0.8mg/day	Women who are planning or capable of pregnancy: Ages 15 – 44
Gonorrhea Screening	Women ages 24 and younger who are sexually active; older if at increased risk
Human Papillomavirus (HPV) DNA testing – Limit of one (1) every five (5) years, with all other testing processing according to contract Benefits. Testing must be completed in conjunction with a routine pap smear.	Ages 30 – 65 years
Intimate Partner Violence Screening	Ages 14 – 46
Mammography Examination • Baseline exam • One (1) exam every twelve (12) months or as doctor prescribes • One (1) exam every twelve (12) months	 Ages 35 – 39 Ages 40 – 49 Ages 50 and older

Medications for Risk Reduction of Primary Breast Cancer	Asymptomatic Women: Ages 35 years or older without a prior diagnosis of breast cancer and who are at increased risk for breast cancer
Osteoporosis Screening: One (1) per Benefit Period	Ages 65 or older; younger women at risk (per guidelines)
Permanent Sterilization Method	Women with reproductive capacity
Routine Gynecologist or Obstetrician Visits	As age and developmentally appropriate
Routine Pap Smear – One (1) per Benefit Period	Ages 21 – 65
Sexually Transmitted Infection Counseling	Sexually active women
Violence and Domestic Abuse Counseling – Annually	Women and adolescent females
COVERED SERVICES FOR PREGNANT FEMALES	
Aspirin – 81mg for prevention of preeclampsia, generic over-the-counter, (Prescription Drug Benefit)	Ages 54 or younger after 12 weeks of gestation
Anemia Screening	During pregnancy
Bacteriuria Screening	During 12 – 16 weeks of gestation or at first prenatal visit
Breast Feeding Intervention	During pregnancy and after birth
Electric and Manual Breast Pumps	During the postpartum period
Gestational Diabetes Testing and Screening	Asymptomatic pregnant women after 24 weeks of gestation
Hepatitis B Screening	During first prenatal visit
Lactation Counseling	During pregnancy and after each birth

Lactation Supplies for Machine Use Only Limit of eight (8) boxes for milk storage bags per Benefit period.	During the postpartum period
Preeclampsia Screening – ***effective 04/01/18***	Throughout the pregnancy
Rh Incompatibility Screening	Pregnant women during 24 – 28 weeks of gestation if at risk or at first prenatal visit
Syphilis Screening	During pregnancy
Tobacco Use Screening and Interventions, with Expanded Counseling	During pregnancy
COVERED SERVICES FOR MALES	
Abdominal Aortic Aneurysm Screening: One (1) per Benefit Period	Men who have smoked: Ages 65 – 75
Permanent Sterilization Method	Ages 18 and older
Prostate Cancer Screening – • Routine digital rectal exam: One (1) per Benefit Period • Second visit: For follow-up treatment within 60 days after the visit if it is related to a condition that is diagnosed or treated during the visit and recommended by a doctor.	Ages 50 and older or as recommended by doctor for ages 40 – 49 Older than 40 years
COVERED SERVICES FOR CHILDREN & ADOLESCENTS	
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels). Limit of one (1) per Benefit Period. High-Tech Imaging services such as an MRI, MRA, CT scan, PET scan, and nuclear cardiology are not covered under this Preventive or Wellness Benefit but may be covered under contract Benefits.	All ages
Well baby care	As recommended by physician for developmental milestones
Immunizations recommended by Physician	All Ages
Seasonal Flu and H1N1 Immunizations	All Ages
Alcohol and Drug Use Assessments	Ages 11 – 21
Autism Screening	Ages 1 – 2

Behavioral Assessments	Ages 0 – 21
Blood Pressure Screening	Ages 0 - 17
Cervical Dysplasia Screening	Adolescent Girls: Ages 11 - 21
Chlamydia Infection Screening	Ages 24 and younger who are sexually active
Congenital Hypothyroidism Screening	Newborns
Depression Screening	Ages 12 – 18
Developmental Screening	Varied Intervals: Ages 0 – 3
Dyslipidemia Screening	Varied intervals beginning at 24 months
Fluoride Chemoprevention Supplements	Ages 6 months – 5 years
Gonorrhea Prophylactic Ocular Medication	Newborns
Gonorrhea Screening	Ages 24 and younger who are sexually active
Hearing Screening: One (1) per Benefit Period.	Ages 0 – 21
Height, Weight and Body Mass Index Measurements	Ages 2 – 21
Hematocrit or Hemoglobin Screening	Varied intervals: Ages 4 months – 21 years
Hepatitis B Screening	High risk adolescents
HIV Screening and Counseling	Adolescents
Intimate Partner Violence Screening	Ages 14 - 46
Lead Screening: One (1) per Benefit Period	Ages 0 – 6
Obesity Screening and Counseling	Ages 6 and older
Oral Health Assessment	Varied intervals between 6 months – 6 years
Phenylketonuria (PKU)	Newborns
Sexually Transmitted Infection Counseling	Sexually active adolescents
Sickle Cell Screening	Newborns
Skin Cancer Counseling	Ages 10 – 24

Tobacco Use Screening and Counseling	School-aged children and adolescents
Tuberculosis Screening: One (1) per Benefit Period	Ages 0 – 21
Violence and domestic abuse counseling	As needed
Vision Screening: One (1) per Benefit Period	Ages 0 – 21

ARTICLE IX. MENTAL HEALTH BENEFITS

A. Treatment of Mental Disorders is covered. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treatment of Mental Disorders do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.

B. Inpatient treatment for Mental Disorders must be Authorized as provided in the Care Management Article of this Benefit Plan.

C. Participants who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis when the Claims Administrator Authorizes it for treatment of Autism Spectrum Disorders. Applied Behavior Analysis must be rendered by an appropriately licensed behavior analyst or certified assistant behavior analyst.

ARTICLE X. SUBSTANCE USE DISORDER BENEFITS

A. Benefits for treatment of substance use disorders are available. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.

B. Inpatient treatment for substance use disorders must be Authorized as provided in the Care Management Article of this Benefit Plan, when coverage for substance use disorders is provided.

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

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

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

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) or a Blue Cross and Blue Shield of Louisiana (BCBSLA) Preferred Provider facility, unless otherwise approved by the Claims Administrator in writing. To locate an approved facility, Plan Participants should contact the Claims Administrator's 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

1. liver;

2. heart;

3. lung;

4. kidney;

5. pancreas;

6. small bowel; and

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

D. Tissue Transplant Procedures (Autologous and Allogeneic)

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

The following tissue transplants are covered:

1. blood transfusions;

2. autologous parathyroid transplants;

3. corneal transplants;

4. bone and cartilage grafting;

5. skin grafting;

6. autologous islet cell transplants; and

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

E. Bone Marrow Transplants

1. Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.

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

ARTICLE XII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

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

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

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

A. Pregnancy Care

1. 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.

3. Elective deliveries prior to the thirty-ninth (39th) week of gestation are not covered unless shown to be Medically Necessary. Facility and other charges associated with an elective early delivery that is not Medically Necessary are also considered to be non-covered.

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

B. Care for Newborn when 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 under the Network Benefit category only.

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.

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

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

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

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

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

ARTICLE XIII. REHABILITATIVE / HABILITATIVE CARE BENEFITS

Rehabilitative and Habilitative Care Benefits will be available for the following services and devices provided on an Inpatient or Outpatient basis, including services for:

- Physical Therapy
- Occupational Therapy
- Speech/Language Pathology Therapy
- Chiropractic Services

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

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

Day Rehabilitation Programs for Rehabilitative Care may be Authorized in place of Inpatient stays for rehabilitation. Day Rehabilitation Programs must be Authorized prior to beginning the program and must begin within seventy-two (72) hours following discharge from an Inpatient Admission for the same or similar condition.

Benefits for these services are subject to limitations shown in the Schedule of Benefits. Benefits under this Article are in addition to, but not a duplication of, the Benefits provided under any other provision of this Benefit Plan. Any Benefits provided under any other provision of this Benefit Plan will not be eligible Benefits under this Article.

A. Occupational Therapy

1. Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his license, including, but not limited to a licensed occupational therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.

2. Occupational Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

3. Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.

4. Prevention, wellness and education related services for Occupational Therapy shall not require a referral.

B. Physical Therapy

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license.

2. Physical Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

3. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.

4. Physical Therapy must be prescribed or referred by a Physician, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, podiatrist or chiropractor when performed under the following circumstances, if listed as a Covered Service:

    a. to children with a diagnosed developmental disability pursuant to the Plan Participant's plan of care;

    b. as part of a Home Health Care agency pursuant to the Plan Participant's plan of care;

    c. to a patient in a nursing home pursuant to the Plan Participant's plan of care;

    d. related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness; or

    e. to an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered 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 function.

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. Chiropractic Services are not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

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

ARTICLE XIV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. Accidental Injury Benefits

1. Benefits are available for dental services only. Coverage is subject to limitations as shown in the Schedule of Benefits.

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. Ground Ambulance Transport Services

   a. Emergency Transport

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

      (1) for the Participant, to or from the nearest Hospital that can provide services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care;

      (2) for 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;

      (3) 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.

   b. Non-Emergency Transport

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

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

(1) unable to get up from bed without assistance;

(2) unable to ambulate; and

(3) unable to sit in a chair or wheelchair.

c. Ground Ambulance Without Transport

Benefits are available for ambulance response and treatment at the scene, without transporting the Plan Participant to a facility for further medical care.

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

2. Air Ambulance Transport Services

a. Emergency Transport

Benefits for air Ambulance Services are available for Emergency Medical Conditions or when the Plan Participant is in a location that cannot be reached by ground ambulance. For Emergency Medical Conditions, the air Ambulance Service must be specifically requested by police or medical authorities present at the site with the Plan Participant in order for air Ambulance Services to be covered.

b. Non-Emergency Transport

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

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

3. Ambulance Service Benefits will be provided as follows:

a. If a Plan Participant pays a periodic fee to an ambulance membership organization with which the Claims Administrator does not have a Provider Agreement, Benefits for expenses incurred by the Plan Participant for its Ambulance Services will be based on any obligation the Plan Participant must pay that is not covered by the fee. If there is in effect a Provider Agreement between the Claims Administrator and the ambulance organization, Benefits will be based on the Allowable Charge.

b. The medical transport services must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits.

c. Benefits are available if transportation is provided for a Plan Participant's comfort or convenience, or when a Hospital transports Plan Participants between parts of its own campus.

C. Attention Deficit/Hyperactivity Disorder

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

D. Bone Mass Measurement

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

1. an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;

2. an individual receiving long-term steroid therapy; or

3. an individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.

Deductible and Coinsurance amounts are applicable.

One (1) osteoporosis screening per Benefit Period may be available to women age 60 and older, under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Preferred Provider.

E. Breast Reconstructive Surgery Services

1. A Plan Participant who is receiving Benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy will also receive Benefits for the following Covered Services:

    a. All stages of reconstruction of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. prostheses; and

    d. treatment of physical complications of all stages of the mastectomy, including lymphedemas.

2. These Covered Services shall be delivered in a manner determined in consultation with the attending Physician and the Plan Participant and, if applicable, will be subject to any Deductible and Coinsurance.

F. 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 condition.

G. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other life-threatening disease or condition. Coverage will be subject to any applicable terms, conditions and limitations that apply under this Benefit Plan, including Copayment, Deductible, or Coinsurance amounts shown in the Schedule of Benefits.

2. A "Qualified Individual" under this section means a Plan Participant that:

    a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition;

    b. And either,

        (1) The referring healthcare professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the requirements in paragraph a, above; or

        (2) The Plan Participant provides medical and scientific information establishing that the Plan Participant's participation in such trial would be appropriate based upon the Plan Participant meeting the conditions described in paragraph a, above.

3. An "Approved Clinical Trial" for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that:

    a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

        (1) The National Institutes of Health.

        (2) The Centers for Disease Control and Prevention.

        (3) The Agency for Health Care Research and Quality.

        (4) The Centers for Medicare & Medicaid Services.

        (5) Cooperative group or center of any of the entities described in paragraphs (1) through (4) above, or the Department of Defense or the Department of Veterans Affairs.

        (6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

    b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

    c. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

    d. The study or investigation is conducted by any of the below Departments, which study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines; (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

        (1) The Department of Veterans Affairs.

(2) The Department of Defense.

(3) The Department of Energy.

4. The following services are not covered:

   a. Non-healthcare services provided as part of the clinical trial;

   b. Costs for managing research data associated with the clinical trial;

   c. The investigational drugs, devices, items or services themselves; and/or

   d. Services, treatment or supplies not otherwise covered under this Benefit Plan.

5. Treatments and associated protocol-related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:

   a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other life-threatening disease or for the prevention or early detection of such diseases.

   b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial.

   c. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.

   d. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

   e. There must be no clearly superior, non-investigational approach.

   f. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.

   g. The patient has signed an institutional review board approved consent form.

H. Dental Services for Head and Neck Cancer Patients

Benefits are available for dental services not otherwise covered by this Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To determine if the Plan Participant is eligible for these Benefits, please call the Claims Administrator's customer service department at the phone number on the Plan Participant's ID card, and ask to speak to a Case Manager.

I. Diabetes Education and Training for Self-Management

1. Plan Participants that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by the Plan Participant's Physician.

2. Evaluation and training programs for diabetes self-management are covered subject to the following:

   a. The program must be determined to be Medically Necessary by a Physician and provided by a licensed healthcare professional who certifies that the Plan Participant has successfully completed the training program.

b. The program shall comply with the National Standard for Diabetes Self-management Education Program as developed by the American Diabetes Association.

J. Dietitian Visits

Benefits are available for visits to registered dietitians.

Dietitian visits for diabetics are available under a separate Benefit for diabetes self-treatment training and education.

K. Disposable Medical Equipment and Supplies

Disposable medical equipment or supplies which have a primary medical purpose are covered and are subject to reasonable quantity limits as determined by the Claims Administrator. The equipment and supplies are subject to the Plan Participant's medical Deductible and Coinsurance.

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered and subject to the Deductible Amount and Coinsurance percentages shown in the Schedule of Benefits.

1. Durable Medical Equipment

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

      (1) it must withstand repeated use;

      (2) it is primarily and customarily used to serve a medical purpose;

      (3) it is generally not useful to a person in the absence of illness or injury; and

      (4) it is appropriate for use in the patient's home.

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

      (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge).

      (2) At the Plan's option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.

      (3) Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Plan Participant selects deluxe equipment solely for his comfort or convenience.

      (4) Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.

      (5) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.

(6) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or damaged due to neglect or misuse or for replacement of equipment within five (5) years of purchase or rental will not be covered.

c. Limitations in connection with Durable Medical Equipment.

(1) There is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.

(2) There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.

(3) There is no coverage for repair or replacement of equipment lost or damaged due to neglect or misuse.

(4) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by the Plan.

2. Orthotic Devices

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

a. There is no coverage for shoe orthotics or any orthotic brace available over-the-counter.

b. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.

c. Repair or replacement of the Orthotic Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. The Plan will determine this time period.

d. Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when a Plan Participant selects a deluxe device solely for his comfort or convenience.

e. Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented to be Medically Necessary.

f. 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 Authorized by the Claims Administrator and are covered subject to the following:

a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.

b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Plan will determine this time period.

c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience.

d. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.

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

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

a. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Plan will determine this time period.

b. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience. A Plan Participant may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Plan and may pay the difference between the price of the device and the Benefit payable, without financial or contractual penalty to the Provider of the device.

c. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.

d. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

M. Hearing Aid Benefits

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

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

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

Benefits are available for hearing aids for covered Plan Participants age eighteen (18) and up. This Benefit is limited to one (1) hearing aid for each ear with hearing loss every thirty-six (36) months and includes repair/replacement. Any combination of Network Benefits and Non-Network Benefits is subject to limitations as shown in the Schedule of Benefits.

N. Home Health Care Benefits

Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered, and are subject to limitations as shown in the Schedule of Benefits.

O. Hospice Benefits

Hospice Care is covered.

P. Permanent Sterilization Procedures and Contraceptive Devices

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

Tubal ligation procedures, hysteroscopic placement of micro-inserts into the fallopian tubes, and vasectomy procedures are covered under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Preferred Provider.

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

IUDs are covered under the Preventive or Wellness Care Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Preferred Provider.

Q. Prescription Drugs

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

R. Routine Vision Care

1. Benefits are subject to the Deductible, Coinsurance, and the limitations shown in the Schedule of Benefits.

S. Sleep Studies

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

T. Telehealth Services

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

Covered Services provided via Telehealth must be rendered by a Physician or Nurse Practitioner in the Preferred Care Network or another Provider approved by the Claims Administrator. The cost a Plan Participant pays for a Telehealth visit may differ from the amounts shown on the Schedule of Benefits for office visits.

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

1. Medically necessary x-rays, lab tests, and machine tests are subject to Deductible and Coinsurance.

2. High-Tech Imaging, including but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology, are subject to Deductible and Coinsurance.

ARTICLE XV. CARE MANAGEMENT

A. Selection of Provider, Penalties for Failure to Obtain Authorization, and Authorization of Admissions, Outpatient Services and Other Covered Services and Supplies

1. Selection of Provider

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

   a. If a Plan Participant wants to receive services from a Non-Network Provider and obtain the highest level of Benefits, he must notify the Claims Administrator's Care Management Department before services are rendered. The Claims Administrator will approve the use of a Non-Network Provider only if the Claims Administrator determines that the services cannot be provided by a Network Provider within a seventy-five (75) mile radius of the Plan Participant's home.

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

   b. If the Claims Administrator does approve the use of a Non-Network Provider, that Provider may or may not accept the Plan Participant's Deductible at the time services are rendered. The Plan 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. The Claims Administrator will deduct from payment the amount of the Plan Participant's Deductible and Coinsurance percentage, whether or not the Deductible and Coinsurance amounts are accepted by the Non-Network Provider.

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

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

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

   If the Admission or Outpatient services were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services, as follows.

   a. Admissions

      (1) If a Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

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

(3) If the Admission was not Medically Necessary, the Admission will not be covered and the Plan Participant must pay all charges incurred during the Admission.

b. Outpatient Services, Other Covered Services and Supplies

(1) If a Network Provider fails to obtain a required Authorization, the Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

(2) If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown in the Schedule of Benefits. The Plan Participant is responsible for all charges not covered and any applicable Deductible amount and Coinsurance percentage.

(3) The Plan Participant remains responsible for the Deductible amount and his applicable Coinsurance percentage.

(4) If a service or supply was not Medically Necessary, the service or supply is not covered.

2. Authorization of Admissions

a. Authorization of Elective Admissions

The Plan Participant is responsible for ensuring that his Provider notifies the Claims Administrator's Care Management Department of any Elective or non-emergency Inpatient Hospital Admission. The Claims Administrator must be notified (by calling the telephone number shown in the Schedule of Benefits or on the Plan Participant's ID card) prior to the Admission regarding the nature and purpose of any Elective Admission or non-emergency Admission to a Hospital's Inpatient department. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Claims Administrator when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If a request for Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission is not covered and the Plan Participant must pay all charges incurred during the Admission for which Authorization was denied.

(2) If Authorization is not requested prior to an Admission, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.

(3) Additional amounts for which the Plan Participant is responsible because Authorization of an Elective or non-emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

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

(1) If Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission will not be covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission for which Authorization was denied.

(2) If Authorization is not requested, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.

(3) Additional amounts for which the Plan Participant is responsible because Authorization of an Emergency Admission was denied or not requested are considered non-covered and will not apply toward the Out-of-Pocket Amount.

c. Concurrent Review

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

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

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

(3) Charges for non-authorized days in the Hospital that the Plan Participant must pay will not apply toward satisfying the Out-of-Pocket Amount.

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

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

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

b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, the Plan will have the right to determine if the services and supplies were Medically

Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider.

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

B. Disease Management

1. Qualification

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

2. Disease Management Benefits

   Our Disease Management programs are committed to improving the quality of care for Plan Participants as well as decreasing healthcare costs in populations with a chronic disease. The nurse works with Plan Participants to help them learn the self-care techniques they will need in order to manage their chronic disease, establish realistic goals for life style modification, and improve adherence to their Physician prescribed treatment plan. Blue Cross and Blue Shield of Louisiana is dedicated to supporting the Physician's efforts in improving the health status and well-being of the Plan Participant.

C. Case Management

1. The Plan Participant may qualify for Case Management services based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.

2. The role of Case Management is to service the Plan Participant by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.

3. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Case Management services will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant. The provision of Case Management services to one Plan Participant will not entitle any other Plan Participant to Case Management services or be construed as a waiver of the Claims Administrator's right, to administer and enforce this Benefit Plan in accordance with its express terms.

4. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Case Management services.

5. The Plan Participant's Case Management services will be terminated upon any of the following occurrences:

   a. The Claims Administrator determines that the Plan Participant is no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.

   b. The short and long-term goals established in the Case Management plan have been achieved, or the Plan Participant elects not to participate in the Case Management plan.

D. Alternative Benefits

1. The Plan Participant may qualify for Alternative Benefits, at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Plan Participant and to the Group.

2. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Alternative Benefits will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant; nor will the provision of Alternative Benefits to a Plan Participant entitle any other Plan Participant to Alternative Benefits or be construed as a waiver of the Claims Administrator's right, to administer and enforce this Benefit Plan in accordance with its express terms.

3. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Alternative Benefits.

4. Alternative Benefits provided under this Article are provided in lieu of the Benefits to which the Plan Participant is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Plan.

5. The Plan Participant's Alternative Benefits will be terminated upon any of the following occurrences:

    a. The Claims Administrator determines, in their sole discretion, that the Plan Participant is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.

    b. The Plan Participant receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by the Claims Administrator.

ARTICLE XVI. LIMITATIONS AND EXCLUSIONS

A. Services, supplies and treatment for services that are not covered under this Plan and complications from services, supplies and treatment for services that are not covered under this 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, or elsewhere in this policy. 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 Plan. Benefits are not payable for services a Plan Participant has no obligation to pay, or for which no charge or a lesser charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions;

   b. rendered or furnished before the Plan Participant's Effective Date;

   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. paid or payable under Medicare Parts A or B when a Plan Participant has Medicare, except when Medicare Secondary Payer provisions apply;

   e. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with the Claims Administrator's policies and procedures for such determinations;

   f. 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);

   g. 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

   h. rendered by a Provider who is the Plan Participant'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. for the treatment of any Plan Participant confined in a prison, jail or other penal institution; or

e. those occurring as a result of a Plan Participant's commission or attempted commission of a felony.

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, except for breast reconstructive services as specifically provided in this Benefit Plan;

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, except services required to be covered by law and those offered, endorsed, approved, or promoted by the Plan Administrator, which may be part of your healthcare coverage under this Benefit Plan, or which may be a value-added program subject to minimal additional cost to You, should You voluntarily choose to participate in the program. Participation in diabetes prevention programs will be limited to once every thirty-six (36) months;

j. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies;

k. industrial testing or self-help programs including, but not limited to stress management programs, work hardening programs and/or functional capacity evaluations, driving evaluations, etc., except services required to be covered by law;

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. eyeglasses or contact lenses or exams (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery);

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; unless shown in the Schedule of Benefits;

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 Plan Participant is a donor except as provided in this Benefit Plan;

   b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;

   c. the transplant of any non-human organ or tissue; 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 for in 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, regardless of Medical Necessity, except as required by law.

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

11. Prescription Drugs that the Claims Administrator determines are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered 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,
       - weight loss (e.g., Xenical®),
       - enhancing 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. Prescription vitamins not listed as covered in the drug formulary (including but not limited to Enlyte).

    f. Nutritional or dietary supplements, or herbal supplements and treatments, except those required to be covered by the United States Preventive Services Task Force preventive services recommendations.

g. Drugs that can be lawfully obtained without a Physician's order, including over-the-counter (OTC) drugs, or except those required to be covered by law.

h. selected Prescription Drugs for which there is an OTC-equivalent or for which a similar alternative exists as an OTC medication;

i. Prescription Drug products that include or are packaged with a non-Prescription Drug product;

j. Prescription Drug compounding kits;

k. selected Prescription Drug products that are packaged in a way that contains more than one Prescription Drug;

l. selected Prescription Drug products that contain more than 1 active ingredient (sometimes called combination drugs);

m. Prescription Drug products that contain marijuana, including medical marijuana;

n. 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.

o. 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.

p. Prescription Drugs filled prior to the Plan Participant's Effective Date or after a Plan Participant's coverage ends.

q. Replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage.

r. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®).

s. 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.

t. Growth hormone therapy, except for chronic renal insufficiency, AIDS wasting, and Turner's Syndrome, Prader-Willi syndrome, Noonan Syndrome, wound healing in burn patients, growth delay in patients with severe burns, short bowel syndrome, short stature homeobox-containing gene (SHOX) deficiency, or growth hormone deficiency when a Physician confirms growth hormone deficiency with abnormal provocative stimulation testing.

u. Prescription Drugs for and/or treatment of idiopathic short stature.

v. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Plan Participant misrepresentation to that prescriber. Limitation may include, but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy.

w. Topically applied prescription preparations that are approved by the FDA as medical devices.

x. Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider, unless the Provider is contracted with the Claims Administrator's pharmacy benefit manager.

y. Covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include but are not limited to intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration as determined by BCBSLA are covered under the medical benefit and excluded under the pharmacy benefit.

z. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Plan Participant's Coinsurance and the Plan's financial responsibility. The Plan will cover the cost of sales tax imposed on eligible Prescription Drugs.

12. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Plan Participant's home or vehicle.

13. Telephone calls, e-mail messages, or instant messages between the Plan Participant and their Provider are excluded. Services billed with Telehealth Services codes not medically appropriate for the setting in which the services are provided. Telehealth Services rendered by a Non-Network Provider is not covered.

14. 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.

15. 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.

16. Any abortion other than to save the life of the mother or if the pregnancy is a result of rape or incest.

17. 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.

18. 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.

19. Prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.

20. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services.

21. Cosmetic Surgery, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly or Mastectomy. Complications resulting from any of these or any other non-covered items are excluded.

22. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under:

    a. Cleft Lip and Cleft Palate Services.

23. Diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to:

    a. malocclusion;

    b. Temporomandibular/Craniomandibular Joint Disorder;

    c. hyperplasia or hypoplasia of the mandible and/or maxilla; and

    d. any orthognathic condition.

24. 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.

25. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.

26. Educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This includes Applied Behavior Analysis (ABA) services that are not habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or Custodial Care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law.

27. 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.

28. Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.

29. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.

30. Hospital charges for a well newborn.

31. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.

32. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan.

33. Medical and surgical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).

34. Paternity tests and tests performed for legal purposes.

35. Reversal of a voluntary sterilization procedure.

36. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by the Claims Administrator. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by the Claims Administrator.

37. Services, Surgery, supplies, treatment, or expenses of a covered Plan Participant related to:

    a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or as required by law;

    b. Pre-implantation genetic diagnosis;

    c. preconception carrier screening; and

    d. prenatal carrier screening except screenings for cystic fibrosis.

38. Services or supplies for the prophylactic storage of cord blood.

39. Sleep studies, unless performed as a home sleep study or in a network-accredited sleep laboratory. If a sleep study is not performed as a home sleep study, not performed by a network-accredited sleep laboratory, or a sleep study is denied, then neither the sleep study nor any professional claims associated with the sleep study are eligible for coverage.

40. Applied Behavior Analysis (ABA) that the Claims Administrator has determined is not Medically Necessary. ABA rendered to Plan Participants age twenty-one (21) and older. ABA rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

41. Private Duty Nursing services.

ARTICLE XVII. CONTINUATION OF COVERAGE RIGHTS

A. Leave of Absence

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

    a. An Employee who is granted leave of absence without pay due to a service related injury may continue coverage and the Employer shall continue to pay its portion of health plan premiums for up to twelve (12) months if the Employee continues his coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

    b. An Employee who suffers a service related injury that meets the definition of a total and permanent disability under the worker's compensation laws of Louisiana may continue coverage and the Employer shall continue to pay its portion of the premium until the Employee becomes gainfully employed or is placed on state disability retirement.

    c. An Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the Employer may continue to pay its portion of premiums if the Employee continues his coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

2. Leave of Absence without Pay – No Employer Contributions to Premiums

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

B. Surviving Spouse/Dependents Continuation

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

    a. The surviving Spouse of an Employee or Retiree may continue coverage unless or until the surviving Spouse is or becomes eligible for coverage under a group health plan other than Medicare or until attainment of the termination age for children, whichever occurs first.

    b. The surviving Dependent child of an Employee or Retiree may continue coverage unless or until such Dependent child is or becomes eligible for coverage under a group health plan other than Medicare, or until end of the month of the attainment of the termination age for that specific Dependent Child, whichever occurs first.

    c. Surviving Dependents will be entitled to receive the same Group premium contributions as Employees and Retirees, subject to the provisions of La. R.S. 42:851 and rules promulgated pursuant thereto by the Office of Group Benefits.

    d. Coverage provided by the Civilian Health and Medical Program of the Uniform Services (CHAMPUS/TRICARE) or successor will not be sufficient to terminate the coverage of an otherwise eligible surviving Spouse or a Dependent child.

    e. A surviving Spouse or Dependent child cannot add new Dependents to continued coverage other than a child of the deceased Employee or Retiree born after the Employee's or Retiree's death.

2. Employee and Dependent Responsibilities

    a. The surviving covered Dependent shall notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree.

    b. The Plan Administrator will notify the surviving Dependents of their right to continue coverage.

    c. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of notification, and premium payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.

3. Coverage for the surviving Spouse under this section will continue until the earliest of the following events:

    a. Failure to pay the applicable premium timely.

    b. Eligibility of the surviving Spouse under a group health plan other than Medicare.

4. Coverage for a surviving Dependent child under this section will continue until the earliest of the following events:

    a. Failure to pay the applicable premium timely.

    b. Eligibility of the surviving Dependent child for coverage under any group health plan other than Medicare.

    c. The end of the month of the attainment of the termination age for that specific Dependent Child.

    d. The provisions of section B above are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree. Continued coverage for surviving Dependents that made such election before July 1, 1999, shall be governed by the rules in effect at the time of the election.

C. Over-Age Dependents

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

    a. Prior to the Dependent child reaching age twenty-six (26), an application for continued coverage, with current medical information from the Dependent child's attending Physician along with the Child's attending Physician's attestation of the Child's incapacity to perform self-sustaining employment, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.

    b. Upon receipt of the application for continued coverage and Physician's attestation, the Plan Administrator may require additional medical documentation regarding the Dependent child's incapacity as often as it may deem necessary as a precondition to continue coverage.

D. Military Leave

1. Employees in the National Guard or in the United States military reserves who are called to active military duty and their covered eligible Dependents will have access to continued coverage under this Benefit Plan subject to submittal of appropriate documentation to the Plan Administrator.

2. When an Employee is called to active military duty, the Employee and their covered eligible Dependents may:

    a. continue participation in the Plan during the period of active military service, in which case the Employer may continue to pay its portion of premiums; or

    b. cancel participation in the Plan during the period of active military service, in which case the Employee may apply for reinstatement of coverage within thirty (30) days of:

        (1) the date of the Employee's re-employment with the Employer; or

        (2) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Employees who elect this option and timely apply for reinstatement coverage, the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding rules promulgated by the Office of Group Benefits.

E. COBRA Continuation

During the period of continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Employees, Retirees and their Dependents

1. Employees

    a. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage..

    b. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification, and premium payment must be made within forty-five (45) days of the date the Employee elects continued coverage. Coverage will be retroactive to the date it would have otherwise terminated.

c. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered Spouse and/or covered Dependent children may elect to continue coverage at his own expense. The elected coverage will be subject to the above stated notification provisions.

2. Surviving Dependents

   a. Coverage under this Plan for covered surviving Dependents of an Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.

   b. The surviving covered Dependent shall notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree. The Plan Administrator will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification.

   c. Premium payment must be made within forty-five (45) days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

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

   a. Coverage under this Plan for an Employee's or Retiree's Spouse (and any stepchildren enrolled in the Plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment, or legal separation from the Employee or Retiree, unless the covered ex-Spouse elects to continue coverage at his own expense.

   b. The Employee / Retiree shall notify the Plan Administrator of the divorce, annulment, or legal separation within sixty (60) days from the date of the divorce, annulment, or legal separation. The Plan Administrator will notify the ex-Spouse (and any stepchildren enrolled in the Plan) within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the election notification.

   c. Premium payment must be made within forty-five (45) days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

4. Dependent Children

   a. Coverage under this Plan for a covered Dependent child will terminate on the last day of the month during which the Dependent child no longer meets the definition of an eligible covered Dependent, unless the Dependent child elects to continue coverage at his own expense.

   b. The Dependent child shall notify the Plan Administrator within sixty (60) days of the date coverage would have terminated. The Plan Administrator will notify the Dependent child within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of the election notification.

   c. Premium payment must be made within forty-five (45) days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

5. Dependents of COBRA Participants

   a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered Spouse or a covered Dependent child becomes ineligible for coverage due to:

      (1) Death of the Employee,

      (2) Divorce, Annulment, or Legal Separation from the Employee, or

      (3) A Dependent child no longer meets the definition of an eligible covered Dependent,

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

   b. The Spouse and/or the Dependent child shall notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.

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

6. Disability COBRA

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

   b. To qualify for disability COBRA, the Plan Participant must:

      (1) Submit a copy of his Social Security Administration's disability determination to the Plan Administrator before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:

         (a) The date of issuance of the Social Security Administration's disability determination; or

         (b) The date on which the qualified beneficiary loses (or would lose) coverage under terms of the Plan as a result of the covered Employee's termination or reduction of hours.

      (2) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of employment, submit proof of total disability to the Plan Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the Plan Administrator will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history and other relevant evidence presented by the applicant.

   c. For purposes of eligibility for extended continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of twelve (12) months. To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

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

7. Medicare COBRA

a. If an Employee becomes entitled to Medicare less than eighteen (18) months before the date the Employee's eligibility for Benefits under this Plan terminates, coverage under this Plan may be extended at his own expense up to a maximum of thirty-six (36) months.

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

8. COBRA continuation coverage will continue until the earliest of the following:

a. Employees

(1) Failure to pay the applicable premium timely;

(2) Eighteen (18) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

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

b. Surviving Dependents, Divorced Spouse, Dependent Children and Dependents of COBRA Participants.

(1) Failure to pay the applicable premium timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

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

c. Disability COBRA

(1) Failure to pay the applicable premium timely;

(2) Twenty-nine (29) months from the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

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

(6) Thirty (30) days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Plan Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the Plan Administrator determines that the Covered Person is no longer disabled.

d. Medicare COBRA

(1) Failure to pay the applicable premium timely;

(2) Thirty-six (36) months from the date of the Employee's Medicare entitlement;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

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

ARTICLE XVIII. COORDINATION OF BENEFITS

A. Applicability

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

2. This Section is intended to describe whether the Benefits of This Plan are determined before or after those of another Plan when this Section applies.

   The Benefits of This Plan:

   a. will not be reduced when, under the terms of this Section and any applicable laws, This Plan determines its Benefits before another Plan.

   b. may be reduced when under the terms of this Section or any applicable laws, another Plan determines its benefits first. That reduction is described in Subsection D of this Section, "When This Plan is Secondary."

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

1. "Allowable Expense" means any healthcare expense, including coinsurance or copayments, and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

   a. If a Plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

   b. An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.

   c. Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

   d. The following are examples of expenses that are not Allowable Expenses.

      (1) if a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the Provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the secondary plan to determine its benefits.

2. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

3. "Claim" a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

   a. services (including supplies);

   b. payment for all or a portion of the expenses incurred;

   c. a combination of prongs a and b of this Subparagraph; or

   d. an indemnification.

4. "Claim Determination Period or Plan Year" a period of not less than 12 consecutive months over which Allowable Expenses shall be compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each Plan will pay or provide.

   a. The claim determination period is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group or individual contract. A person is covered by a Plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

   b. As each claim is submitted, each Plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same claim determination period.

5. "Closed Panel Plan" a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

6. "Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA" coverage provided under a right of continuation pursuant to federal law.

7. "Coordination of Benefits or COB" a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable Expenses.

8. *"*Custodial Parent"

   a. the parent awarded custody of a child by a court decree; or

   b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

9. "Group Insurance Contract" means an insurance policy or coverage that is sold in the group market and that are usually sponsored by a person's employer, union, employer organization or employee organization.

10. "Group-Type Contract" a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

11. *"*High-Deductible Health Plan" the meaning given the term under section 223 of the *Internal Revenue Code* of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

12. *"*Hospital Indemnity Benefits" benefits not related to expenses incurred. Hospital indemnity benefits does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

13. "Individual Insurance Contract" means an insurance policy or coverage that is sold to an individual and/or his/her family in the individual market.

14. Plan" a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its Benefit Plan shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the Benefit Plan uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this Subsection.

    a. Plan includes:

        (1) Group Insurance Contracts, Individual Insurance Contracts and Subscriber contracts;

        (2) uninsured arrangements of group or Group-Type coverage;

        (3) group and non-group coverage through closed panel plans;

        (4) Group-Type Contracts;

        (5) the medical care components of long-term care contracts, such as skilled nursing care;

        (6) the medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;

        (7) Medicare or other governmental benefits, as permitted by law, except as provided in Subparagraph b of this definition. That part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program; and

(8) group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

b. Plan does not include:

(1) hospital indemnity coverage benefits or other fixed indemnity coverage;

(2) accident only coverage;

(3) specified disease or specified accident coverage;

(4) limited benefit health coverage as defined in La. R.S. 22:47(2)(c), except for group and non-group dental coverage;

(5) school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;

(6) benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(7) Medicare supplement policies;

(8) a state plan under Medicaid; or

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

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

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

A plan is a primary plan if:

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

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

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

18. "Secondary Plan" a plan that is not a primary plan.

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

C. Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

b. Dependent Child Covered Under More Than One Plan Rule. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(a) The Plan of the parent whose Birthday falls earlier in the calendar year is the Primary plan; or

(b) If both parents have the same Birthday, the Plan that has covered the parent the longest is the Primary plan.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial parent;

(b) The Plan covering the Spouse of the Custodial parent;

(c) The Plan covering the non-custodial parent; and the

(d) The Plan covering the Spouse of the non-custodial parent.

(5) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provision s of Subparagraphs (2)(b)(1) or (2)(b)(2) above shall determine the order of benefits as if those individuals were the parents of the child.

(6) For a dependent child covered under the Spouse's plan:

(a) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a Spouse's plan, the rule in Subparagraph (2)(e) (Longer or Shorter Length in Coverage) applies.

(b) In the event the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule above in Subparagraph (2)(b)(1) to the dependent child's parent(s) and the dependent's Spouse.

c. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does n ot apply if the rule of Subparagraph (2)(a) can determine the order of benefits.

d. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(a) determine the order of benefits.

e. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an employee, member, policyholder, Subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

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

The start of a new Plan does not include:

(1) a change in the amount or scope of a Plan's benefits;

(2) a change in the entity that pays, provides or administers the Plan's benefits; or

(3) a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

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

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

D. When This Plan is Secondary

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

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

A payment made under another plan may include an amount, which should have been paid under This Plan. We 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 Us from further liability. The term "payment made" includes providing Benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any Benefits provided in the form of services.

G. Right of Recovery

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

1. the persons it has paid or for whom it has paid;

2. insurance companies; or

3. other organizations.

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

ARTICLE XIX. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

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

A. The Benefit Plan

1. Except as specifically provided herein, this Benefit Plan will not make the Claims Administrator liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations.

    a. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the Plan Administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those specifically undertaken by Us herein.

    b. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group's failure to do so.

    c. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the 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 the case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition.

2. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.

3. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.

4. The (Plan Administrator) shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

B. Amending and Terminating the Benefit Plan

The Employer intends to maintain this Benefit Plan indefinitely; however, it reserves its right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the Benefits under the plan or the trust agreement, if any.

C. Identification Cards and Benefit Plans

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

D. Benefits Which Plan Participants are Entitled

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Benefit Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

E. Termination of a Plan Participant's Coverage

1. Termination of Coverage

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

   a. The date the Plan terminates;

   b. The date contribution is due if the Plan Participant fails to make any contribution which is required for the continuation of coverage;

   c. The last day of the month of the Plan Participant's death;

   d. The last day of the month in which the Plan Participant ceases to be eligible as an Employee/Retiree or Dependent.

F. Filing Claims

1. You must file all Claims within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than fifteen (15) months from the date services were rendered.

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

G. Applicable Law

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

H. Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.

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

I. Release of Information

The Claims Administrator may request that the Plan Participant or the Provider furnish certain information relating to the Plan Participant's Claim for Benefits. The Claims Administrator will hold such information, records, or copies of records as confidential except where in the Claims Administrator's discretion the same should be disclosed.

J. Assignment

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

2. The Plan reserves the right to pay Preferred Providers directly instead of paying the Plan Participant.

K. Plan Participant/Provider Relationship

1. The choice of a Provider is solely the Plan Participant's.

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

3. The use or non-use of an adjective such as Preferred Network, Participating, and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

L. 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 Plan or under Medicare.

    a. Where such Employee or such Spouse elects coverage under this Plan, this Plan will be the primary payor of Benefits with the Medicare program the secondary payor.

    b. This 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 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 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 Plan will be the primary payor and Medicare the secondary payor.

4. When this Plan is the primary payor, it will provide regular Benefits for Covered Services.

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

M. Notice

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

N. Job-Related Injury or Illness

The Group must report to the appropriate governmental agency any job-related injury or illness of an Employee where so required under the provisions of any legislation of any governmental unit. This Plan, with certain described exceptions, excludes Benefits for any services covered in whole or in part by Workers' Compensation laws and/or rendered as a result of occupational disease or injury, subject to the provisions of La. R.S. 23:1205(C). In the event Benefits are initially extended by the Plan and a compensation carrier or employer makes any type of settlement with the Employee, or with any person entitled to receive settlement where the Employee dies, or if the Employee's injury or illness is found to be compensable under law, the Employee must reimburse the Plan for Benefits extended or direct the compensation carrier to make such reimbursement. The Group will be entitled to such reimbursement even if the settlement does not mention or excludes payment for healthcare expenses.

O. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Group will be subrogated and will succeed to the Plan Participant's right 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 Plan Participant who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights.

2. The Plan Participant will reimburse the Plan all amounts recovered by suit, settlement, or otherwise from any third party or the Plan Participant's insurer to the extent of the Benefits provided or paid under this Plan. The Plan's right to reimbursement comes first even if the Plan Participant is not paid for all of the Plan Participant's Claim for damages against the other person or organization or even if the payment the Plan Participant receives is for, or is described as for, the Plan Participant's damages other than healthcare expenses, or if the Plan Participant recovering the money is a minor. All costs that the Plan Participant incurs (including attorney fees) in exercising any right of recovery will be the Plan Participant's responsibility. Amounts that the Plan paid for which a third party or insurer is responsible will not be reduced by the amount of the Plan Participant's costs. The Plan Participant shall hold in trust for the account of the Plan all amounts recovered, up to the total amount of Benefits paid. The Group appoints the Plan Participant as its representative for such limited purpose only.

3. The Plan Participant will take such action, furnish such information and assistance, and execute such papers as the Plan may be required to facilitate enforcement of the Plan's rights, and will take no action prejudicing the Plan's rights and interest under this Plan. The Plan and its designees have the right to obtain and review Plan Participant's medical and billing records, if the Plan or its designee determines in their 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 Article of this Benefit Plan.

4. The Plan Participant is required to notify the Plan of any Accidental Injury.

P. Right of Recovery

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

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

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

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

R. Liability of Plan Affiliates

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

S. Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

1. BlueCard® Program

   Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what We agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

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

   - the billed charges for Your Covered Services; or
   - the negotiated price that the Host Blue makes available to the Claims Administrator.

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

2. Special Case: Value-Based Programs

   a. BlueCard® Program

      If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

   b. Negotiated (non-BlueCard Program) Arrangements

      If the Claims Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on Your behalf, the Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

   Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the Claim charge passed on to You.

4. Non-Participating Providers Outside Blue Cross and Blue Shield of Louisiana's Service Area

   a. Plan Participant Liability Calculation

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

   b. Exceptions

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

5. Blue Cross Blue Shield Global Core

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

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

a. Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global Core service center for assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global Core service center to begin Claims processing. However, if You paid in full at the time of service, You must submit a Claim to receive reimbursement for Covered Services. You must contact the Claims Administrator to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Benefit Plan.

b. Outpatient Services

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

c. Submitting a Blue Cross Blue Shield Global Core Claim

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

T. Certificates of Creditable Coverage

The Claims Administrator will issue a certificate of Creditable Coverage or similar document to a Plan Participant, if requested within twenty-four (24) months after coverage under this Benefit Plan ceases.

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

The Claims Administrator shall provide to certain Plan Participants who have Prescription Drug coverage under this Benefit Plan, without charge, a written certification that their Prescription Drug coverage under this Plan is either creditable or non-creditable. Coverage is deemed creditable if it is at least as good as the standard Medicare Part D prescription drug benefit. Claims Administrator will provide these Certificates to covered Group Plan Participants who are eligible for Medicare Part D based upon enrollment data. The Plan Administrator is responsible for providing a certificate to applicants prior to the Effective Date of coverage for new Medicare-eligible persons that join this Plan.
The Claims Administrator will provide Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to covered Plan Participants at the following times, or as designated by law:

1. prior to the Medicare Part D Annual Coordinated Election Period;

2. prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D;

3. whenever Prescription Drug coverage under this Benefit Plan ends;

4. whenever Prescription Drug coverage under this Plan changes so that it is no longer creditable or becomes creditable; and/or

5. upon a Medicare beneficiary's request.

V. Continued Coverage During a Leave of Absence

1. Family Medical Leave

   The Family Medical Leave Act (FMLA) allows eligible Employees to take up to twelve (12) weeks of unpaid FMLA leave in a 12-month period for the following reasons:

   a. a serious health condition that makes You unable to perform Your job;

   b. to care for a seriously ill dependent child, Spouse or parent; or

   c. for the birth, placement for adoption or foster care of a child.

      A serious health condition is an illness, injury, impairment, or physical/mental condition involving either Inpatient care or continuing treatment by a healthcare Provider. Leave may be taken intermittently or on a reduced schedule only if Medically Necessary. If leave is taken on an intermittent basis, the arrangement must be agreed to in advance by the Employee and the Group. Certification of a serious health condition must be provided in writing to the Group. To be eligible for FMLA, an Employee must have completed twelve (12) months of employment and have worked at least 1,250 hours during the 12-month period preceding the leave requested.
      The Plan will continue coverage for Employee during any leave of absence the Group is required to provide by applicable federal or state law, including FMLA and any amendments or successor provisions, as long as eligibility criteria under the law continues to be met. If Employee's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, Employee is entitled to re-enroll for coverage. If the Employee is not restored to active full-time employment by the end of the leave of absence period, the Employee will cease to be eligible and coverage for the Employee 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 Plan Participant's Coverage."

2. Disability Leave

   When an Employee is not actively at work due to a health condition, Plan will maintain coverage for the Employee and any Dependents, as long as the Employee remains a bona fide Employee of the Group and required contributions are paid. If Group terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan Participant's Coverage."

3. Other Employer-Approved Leave of Absence

   When an Employee has been granted a documented, approved leave of absence by the Employer, the Plan will maintain coverage for the Employee and any Covered Dependents for a period not to exceed ninety (90) days. Employee must remain a bona fide Employee of the Group during the approved leave period. The Employer will provide Company with proof of the documented leave, upon request. If the Employer terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan Participant's Coverage."

W. Compliance with HIPAA Privacy Standards

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

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

1. General

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

2. Permitted Uses and Disclosures

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

3. Authorized Employees

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

   a. Updates Required. The Employer shall amend the plan promptly with respect to any changes in the Employees of its workforce who are authorized to receive Protected Health Information.

   b. Use and Disclosure Restricted. An authorized Employee of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

   c. Resolution of Issues of Noncompliance. In the event that any Plan Participant of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

      (1) investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

      (2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;

(3) mitigating any harm caused by the breach, to the extent practicable; and

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

4. Certification of Employer

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

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

b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Employer;

d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. ensure the adequate separation between the Plan and Employee of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

The following Employees of the Vermilion Parish School Board workforce are designated as authorized to receive Protected Health Information from Vermilion Parish School Board PPO ("the Plan") in order to perform their duties with respect to the Plan:

Insurance Specialist; Chief Financial Officer

X. Compliance with HIPAA Electronic Security Standards

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

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health

Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections (3) Authorized Employees and (4) Certification of Employers described above in this Article.

ARTICLE XX. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The Claims Administrator wants to know when a Plan Participant is dissatisfied about the care or services they receive from the Claims Administrator or one of Our Providers. Plan Participants may register a Complaint, or file a formal written Grievance about the Claims Administrator or a Provider by following the procedures outlined below.

The Plan considers a written Appeal as the Plan Participant's request to change an Adverse Benefit Determination made by the Claims Administrator. An Appeal is defined as a request from a Plan Participant or their authorized representative to change a previous decision made by the Claims Administrator about Covered Services. Examples of issues that qualify as Appeals include denied Authorizations, Claims denied based on adverse determinations of Medical Necessity, or other adverse Benefit determinations. Adverse Benefit determinations include denials of and reductions in Benefit payments.

Appeal rights for Plan Participants are outlined below, after the Complaint and Grievance Procedures. In addition to the Appeal rights, the Plan Participant's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of the Claims Administrator's coverage decisions when the coverage decision concerns Medical Necessity or Investigational determinations.

An expedited Appeal process is available for situations where the standard time frames would seriously jeopardize the life or health of a covered person, jeopardize the covered person's ability to regain maximum function.

A. Complaint, Grievance and Informal Reconsideration Procedures

A quality of service concern addresses the Claims Administrator's services, access, availability or attitude and those of the Claims Administrator's Network Providers. A quality of care concern addresses the appropriateness of care given to a Plan Participant.

1. To Register a Complaint

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

   Call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370 to register a Complaint. The Claims Administrator will attempt to resolve a Plan Participant's Complaint at the time of their call.

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with the Claims Administrator or with Provider services. If a Plan Participant does not feel their Complaint was adequately resolved or the Plan Participant wishes to file a formal Grievance, a written request submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, the Plan Participant may call the Claims Administrator's customer service department. Send written Grievances 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 Plan Participant within thirty (30) business days of receipt of the Plan Participant's receives written Grievance.

3. Informal Reconsideration

An Informal Reconsideration is a request by telephone made by an authorized Provider to speak to the Claims Administrator's Medical Director or a peer reviewer on the Plan Participant's behalf about a Utilization Management decision that the Claims Administrator has 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. The Claims Administrator will conduct an Informal Reconsideration within one (1) working day of the receipt of the request.

B. Standard Appeal Procedures

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

If the Plan Participant has questions or need assistance putting the Appeal in writing, the Plan Participant may call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370.

The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

The Claims Administrator will determine the Plan Participant's Appeal is an administrative Appeal or a medical Appeal. There are two (2) levels of each Appeal, the first by the Claims Administrator or its designee, and the second by the Plan Administrator, Vermilion Parish School Board.

Plan Participants are encouraged to provide the Claims Administrator with all available information to help completely evaluate the Appeal such as written comments, documents, records, and other information relating to the Adverse Benefit Determination. Upon request by the Plan Participant and free of charge, the Claims Administrator will provide reasonable access to and copies of all documents records, and other information relevant to the Adverse Benefit Determination.

The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in their Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in a review of an Adverse Benefit Determination. The authorized representative may be the Plan Participant's treating Provider, if the Plan Participant appoints the Provider in writing.

1. Administrative Appeals

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

a. First Level Administrative Appeal

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

The Claims Administrator will investigate the Plan Participant's concerns. If the administrative Appeal is overturned, the Claims Administrator will reprocess the Plan Participant's Claim, if any. If the administrative Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process. The administrative Appeal decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) calendar days of the Plan Participant's request; unless the Claims Administrator mutually agrees that an extension of the time is warranted.

Administrative Appeals should be submitted in writing to:

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

b. Second Level Administrative Appeals

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

Brandy Babineaux
Vermilion Parish School Board
220 S. Jefferson Street
Abbeville, LA 70510

Requests submitted to the Claims Administrator will be forwarded to Vermilion Parish School Board.

2. Medical Appeals

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

a. First Level Medical Appeals (Internal)

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

Medical Appeals should be submitted in writing to:

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

Requests submitted to the Claims Administrator after one hundred eighty (180) days of the initial Adverse Benefit Determination will not be considered.

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

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

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

b. Second Level Medical Appeals (External)

If the Plan Participant still disagrees with the determination on their Claim, the Plan Participant or their authorized representative must send their written request for an external Appeal, within one hundred twenty (120) days of receipt of the internal Appeal decision, to:

Brandy Babineaux
Vermilion Parish School Board
220 S. Jefferson Street
Abbeville, LA 70510

The Group will review and notify the Claims Administrator to proceed with an external Appeal conducted by a non-affiliated Independent Review Organization (IRO). Requests submitted to the Plan Administrator after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered. The Plan Participant is required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. **Appeals submitted by your Provider will not be accepted without this form completed with Your signature.**

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

The IRO decision is considered final and binding.

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

C. Expedited Appeals

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

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

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the covered person's treating Physician certifies in writing that

the recommended or requested healthcare service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

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

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

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

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

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

1. Expedited Internal Medical Appeals

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

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

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

2. Expedited External Medical Appeals

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

ARTICLE XXI. CARE WHILE TRAVELING, MAKING PLAN CHANGES AND FILING CLAIMS

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

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

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

A. How to Obtain Care While Traveling

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

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

2. Call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest Preferred Network doctors and Hospitals.

3. Use a designated Preferred Provider to receive the highest level of Benefits.

4. Present the Plan Participant's ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.

5. The Plan Participant must obtain any required Authorizations from Blue Cross and Blue Shield of Louisiana.

B. Adding or Changing the Plan Participant's Family Members on the Plan

The Schedule of Eligibility lets the Plan Participant know when it is necessary to enroll additional family members for Dependent coverage under the Plan. Please read the Schedule of Eligibility Article and this section as they contain important information for the Plan Participant.

Group may require the Employee to use the Group Enrollment Change Form to enroll family members not listed on the Employee's original enrollment form. If the Plan Participant does not complete and return a required Group Enrollment Change Form to the Plan so the Claims Administrator receives it within the timeframes set out in the Schedule of Eligibility, it is possible that the Employee's health benefits coverage will not be expanded to include the additional family members. Completing and returning a Group Enrollment Change Form is especially important when the Employee's first Dependent becomes eligible for coverage or when the Employee no longer has any eligible Dependents.

The Schedule of Eligibility explains when coverage becomes effective for new family members. Generally, a Group Enrollment Change Form is used to add newborn children, newborn adopted children, a Spouse, or other Dependents not listed on the Employee's original enrollment form. The Plan should receive the Plan Participant's completed form within thirty (30) days of the child's birth or placement, or the Employee's marriage.

C. How to File Claims for Benefits

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

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

1. an appropriate Claim form is used

2. the contract number (ID #) shown on the form is identical to the number on the ID card

3. the patient's date of birth is listed

4. the patient's relationship to the Employee is correctly stated

5. all charges are itemized, whether on the Claim form or on the attached statement

6. the itemized statement from the Provider contains the Provider's name, address and tax ID number and is attached to the Claim form

7. the date of service (Admission to a Hospital or other Provider) or date of treatment is correct

8. the Provider includes a diagnosis and procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)

9. the Claim is completed and signed by the Plan Participant and the Provider.

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

D. Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

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

2. Outpatient Department Claims

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

3. Emergency Room Claims

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

4. Prescription Drug Claims

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

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

5. Nursing Services Claims

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

6. 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.

7. Mental Health and/or Substance Use Disorder Claims

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

8. Other Medical Claims

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

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

   a. full name of patient

   b. date(s) of service

   c. description of and procedure code for service

   d. diagnosis code

   e. charge for service

   f. name and address of Provider of service.

E. If Plan Participant Has a Question about His Claim

Plan Participants can view information about the processing or payment of a claim online at **www.bcbsla.com**.

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

Blue Cross and Blue Shield of Louisiana
PO Box 98029
Baton Rouge, LA 70898-9029

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

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

ARTICLE XXII. RESPONSIBILITIES OF PLAN ADMINISTRATOR

A. Plan Administrator

The Vermilion Parish School Board Health Plan is the Benefit Plan of Vermilion Parish School Board, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by Vermilion Parish School Board to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Vermilion Parish School Board shall appoint a new Plan Administrator as soon as reasonably possible.

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

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

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

B. Duties of the Plan Administrator

1. to administer the Plan in accordance with its terms;

2. to interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;

3. to decide disputes that may arise relative to a Plan Participant's rights;

4. to prescribe procedures for filing a Claim for Benefits and to review Claim denials;

5. to keep and maintain the Plan documents and all other records pertaining to the Plan;

6. to appoint a Claims Administrator to pay Claims;

7. to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

C. Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

D. Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

1. Fiduciary Duties

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

   a. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

   b. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

   c. in accordance with the Plan documents.

2. The Named Fiduciary

   A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

   a. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

   b. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

E. The Claims Administrator is not a Fiduciary

A Claims Administrator is NOT a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

ARTICLE XXIII. GENERAL PLAN INFORMATION

NAME OF PLAN: Vermilion Parish School Board High Deductible Health Plan

NAME AND ADDRESS OF EMPLOYER/PLAN SPONSOR: Vermilion Parish School Board

220 S. Jefferson Street
Abbeville, LA 70510

EMPLOYER IDENTIFICATION NUMBER (EIN) 72-6001434

PLAN NUMBER (PN): 501

TYPE OF PLAN: HDHP

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

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

PLAN ADMINISTRATOR: Vermilion Parish School Board
220 S. Jefferson Street
Abbeville, LA 70510
337-898-5844

AGENT FOR SERVICE OF LEGAL PROCESS: Vermilion Parish School Board
220 S. Jefferson Street
Abbeville, LA 70510
337-898-5844

Service for legal process may be made upon the Plan Administrator or if applicable, a Plan Trustee.

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

BCBSLA has been hired to process Claims under the Plan. BCBSLA does not serve as an insurer, but merely as a claims processor. Claims for Benefits are sent to BCBSLA. BCBSLA processes and pays Claims, then requests reimbursement from the Plan. Vermilion Parish School Board, is ultimately responsible for providing Plan Benefits, and not BCBSLA.

PLAN YEAR ENDS: December 31st

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

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