



GROUP POINT OF SERVICE BENEFIT PLAN

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A subsidiary of Blue Cross and Blue Shield of Louisiana,
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**HMO LOUISIANA, INC. POINT OF SERVICE
BENEFIT PLAN
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INTRODUCTION

HMO Louisiana, Inc. issues this Benefit Plan to the Group/Policyholder shown on the Schedule of Benefits. A copy of this Benefit Plan provided to Subscribers serves as the Subscriber's certificate of coverage. As of the Benefit Plan Date shown on the Group's Schedule of Benefits, We agree to provide the Benefits specified herein for Subscribers of the Group and their enrolled Dependents. This Benefit Plan replaces any others previously issued to the Group/Policyholder, as of the Benefit Plan Date.

Except for necessary technical terms, We use common words to describe the benefits provided under this Benefit Plan. "We," "Us" and "Our" means **HMO Louisiana, Inc.** (HMOLA). Capitalized words are defined terms in Article I - "Definitions." A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

FACTS ABOUT THIS HMO POINT OF SERVICE PLAN

This plan is a Point of Service plan that combines traditional Health Maintenance Organization (HMO) coverage with indemnity coverage for out-of-network care. Typically under a traditional HMO plan, the Member will receive benefits only if care is received by an HMO provider. Under a traditional HMO plan, in most cases, the Member will receive benefits only if he obtains Authorizations prior to the service being rendered. But under this Point of Service plan, the Member will still receive benefits for Covered Services if he receives care outside the HMOLA Provider Network or if he fails to obtain any required Authorizations provided the care rendered is deemed medically necessary. The choices that a Member makes about his Providers and about Authorizations will affect the amount that We pay and the amount that the Member pays for Covered Services.

This is a direct access plan. This means a Member does not need to contact his Primary Care Physician in order to access care from a Specialist in the HMOLA Network to receive the highest level of Benefits.

OUR HMOLA PROVIDER NETWORK

Member's have the right to use a Provider of their choice. The Member's choice of Provider will impact the amount We pay for Covered Services.

HMO Louisiana, Inc. has put together a Provider Network consisting of a select group of Physicians, Hospitals and other Allied Providers that have contracted with Us to participate as HMOLA Network Providers and render Covered Services to Our Members. Members may see Us refer to these Providers as HMOLA, Network, or In-Network Providers. Oral Surgery Benefits are also available when rendered by Providers in the Blue Cross and Blue Shield of Louisiana Key Dental Network.

We use the term "Network Benefits" to mean the highest level of Benefits payable under this plan when the Member uses Providers in the HMOLA Network. We use the term "Non-Network Benefits" to mean a lower level of payment, if a Member chooses to receive care outside the HMOLA Network. (No payment will be made for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless We Authorize these services and the services are rendered by a Blue Distinction Center for Transplants or a transplant facility in our HMOLA network, unless otherwise approved by Us in writing. To locate an approved transplant facility, Members should contact Our Customer Service Department at the number listed on their ID card.)

To receive Network Benefits, the Member should always verify, prior to obtaining non-emergency care, that a Provider is a current HMOLA Network Provider. Members may review a current paper Provider directory, check on-line at www.bcbsla.com, or contact Our Customer Service Department at the number listed on their ID card. Our Network may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. In an emergency, always go to the nearest facility, even if this facility is not in the HMOLA Network.

Network Benefits apply when the Member uses an HMOLA Network Provider. If the Network Provider is required to obtain an Authorization from Us prior to an Admission or rendering a service to the Member, and fails to do so, Our benefit payment to that Provider may be reduced by the amount shown in the Schedule of Benefits for the Admission and/or service. The Member will continue to be responsible for his Network Copayment, Deductible, and/or Coinsurance shown in the Schedule of Benefits.

Using a Provider outside the HMOLA Network will result in Our payment of a lower level of benefits. No benefits are available if the care provided is deemed not Medically Necessary.

A provider may be contracted with Us when providing services at one location, and may be considered out-of-network when rendering services from another location. The Member should check his provider directory to verify that the services are in-network from the location where the Member is seeking care.

You should know that care received from a non-network physician, facility or other health care professional means a higher copayment, deductible, and coinsurance. In addition, if you choose to seek care outside the network, We only pay a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges before you receive care.

SELECTING AND USING A PRIMARY CARE PHYSICIAN

At the time the Subscriber completes his enrollment form, the Subscriber and each of his covered Dependents has the option of selecting a Primary Care Physician from the list of Family Practitioners, General Practitioners, Internists and Pediatricians in Our Provider Directory. The Subscriber may select a Primary Care Physician for the entire family or select a different Primary Care Physician for each individual family member. If a Member wishes to notify Us of the selection of a Primary Care Physician, please call Our Customer Service Department at the number listed on the Member's ID card.

The Subscriber's Dependent who is regularly located outside of the Subscriber's defined Service Area may elect to receive Dependent Out-of-Area Benefits under this Benefit Plan. A Dependent that receives Dependent Out-of-Area Benefits does not choose a Primary Care Physician.

The Role of the Primary Care Physician

The Primary Care Physician provides and should coordinate the majority of the Member's health care needs from consultation to hospitalization. The Primary Care Physician will direct the Member to an appropriate Provider when necessary and will assist in obtaining any required Authorizations.

When the Primary Care Physician Is Not Available

Primary Care Physicians are responsible for providing twenty-four (24) hour coverage for their patients. If a Member requires non-Emergency medical care after normal business hours, or on weekends or holidays, he should contact the Primary Care Physician's office. If the Primary Care Physician is unavailable, his office staff may direct the Member to a covering Physician.

A Member may also visit an Urgent Care Center if he requires non-Emergency medical care. For a list of Urgent Care Centers in the HMOLA Network, please consult Our HMOLA Provider Directory at www.bcbsla.com, or phone Customer Service at the number listed on the Member's ID card.

AUTHORIZATIONS

Some services and supplies require prior Authorization. See the Schedule of Benefits for a list of these services and supplies. An Authorization is Our determination that it is Medically Necessary for the Member to receive the requested medical services. When We Authorize a service for Medical Necessity, We are not making a determination about the Member's choice of Provider. When We issue an Authorization and the Member receives the service from a non-HMOLA Provider, (a Participating or Non-Participating Provider), We will pay a lower level of Benefits, even when We have Authorized the services as Medically Necessary. To receive the highest level of benefits under this plan, remember to obtain non-emergency care from a Provider who is contracted with our HMOLA Network.

If an HMOLA Provider directs or refers a Member to another Provider, it is the responsibility of the Member to make sure that the new Provider is in the HMOLA Network Provider, if the Member wants to receive Network Benefits.

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

HOW WE DETERMINE WHAT WE PAY FOR THE MEMBER'S COVERED SERVICES (Please see next section for information regarding Dependent Out-of-Area Benefits)

NOTICE: THE MEMBER'S SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE

AGREEMENT BETWEEN THE MEMBER'S HEALTH PLAN AND THE MEMBER'S PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW THE MEMBER'S PROVIDER TO BILL THE MEMBER FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

We base Our payment of Benefits for the Member's Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom a Member receives Covered Services, as seen in the examples below.

(1) What We pay When a Member uses Network Providers

Network Providers are Providers that have signed contracts with Us to participate in the HMO Louisiana, Inc. Provider Network. These Providers have agreed to accept the lesser of billed charges or the amount We negotiated as payment in full for Covered Services provided to the Member. This amount is the HMOLA Provider's Allowable Charge and it is used to determine Our payment for the Member's Covered Services. Members who use these Network Providers will receive Network Benefits and will pay the amounts shown in the "Network" column on their Schedule of Benefits for these services.

(2) What We pay When a Member uses Participating Providers

Participating Providers are Providers that have not signed contracts with HMO Louisiana, Inc., but have signed contracts with Our parent company, Blue Cross and Blue Shield of Louisiana, or other Blue Cross and Blue Shield plans to participate in their Provider networks. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services provided to the Member. This amount is the Participating Provider's Allowable Charge and it is used to determine the amount that We pay for the Member's Covered Services when the Member uses a Participating Provider. A Member receiving Covered Services from a Participating Provider will receive a lower level of payment than using a Network Provider. The Member will pay the amounts shown in the "Non-network" column on their Schedule of Benefits for these services.

(3) What We pay When a Member uses Non-Participating Providers

Non-Participating Providers are Providers that have no contract with the HMOLA Network, with Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan. These Providers are not in our networks and We have no fee arrangements with them. The Company establishes an Allowable Charge for Covered Services provided by Non-Participating Providers that is based on the negotiated fee that is accepted by contracted Providers. When a Member uses a Non-Participating Provider, this Allowable Charge is used to determine the Company's payment for a Member's Covered Services and the amount that the Member must pay for Covered Services. A Member receiving Covered Services from a Non-Participating Provider will receive a lower level of payment than using a Network Provider. The Member will pay the amounts shown in the "Non-Network" column on their Schedule of Benefits, and the Provider may balance bill the member for the amounts not paid by HMO Louisiana, Inc.

Members usually pay significant costs when using Non-Participating Providers. This is because the amounts that some Providers charge for Covered Service are usually higher than the negotiated fees that are accepted by HMOLA and Participating Providers. Also, HMOLA and Participating Providers waive the difference between the actual billed charge for Covered Services and the Allowable Charge, while Non-Participating Providers do not.

(4) What We pay when a Member receives Emergency Medical Services Outside the HMOLA Network

In an emergency, Members should seek care from the nearest facility, even if that facility is not in the HMOLA Network. When we receive the claim for Medically Necessary Emergency services, We will pay Network Benefits. **Members do not need to request an Authorization prior to obtaining Emergency Medical Services.**

ILLUSTRATION

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

A Member has this Point of Service plan with a \$15 Copayment. The Non-Network Benefits are 70% - 30% coinsurance with a Deductible. Assume the Member has met his Deductible and has obtained the necessary Authorization prior to receiving the service. The Provider's billed charge for the Covered Service is \$300. We have negotiated an Allowable Charge of \$100 with HMOLA Network Providers to render this service. We have negotiated an Allowable Charge of \$200 with Participating Providers to render this service.

The Member receives			
Covered Services from:	HMOLA Provider	Participating Provider	Non-Participating Provider
Covered Service:	\$300	\$300	\$300
Allowable Charge:	\$100	\$200	\$100
The Member pays:	\$ 15 (Member's Copayment)	30% x \$200 (\$60)	30% x \$100 (\$30)
We pay:	\$ 85 (Allowable Charge less Copayment)	70% x \$200 (\$140)	70% x \$100 (\$70)
Will the Member be billed for the balance?:	NO	NO	YES
TOTAL MEMBER PAYS:	\$ 15	\$ 60	\$230 \$30 (\$100 x 30%) plus the \$200 difference between the \$300 billed charge and the \$100 Allowable Charge

(5) What We pay When a Member uses Non-Participating Providers Who are Radiologists, Anesthesiologists, Pathologists, Emergency Room Physicians, Hospitalists, Intensivists, or Other On-Call Physicians

Our payment for services rendered by Non-Participating radiologists, anesthesiologists, pathologists, emergency room physicians, hospitalists, intensivists, or other on-call physicians is determined in part on the facility in which the Member receives the services. Please note that the provisions below apply only to the types of physicians listed specifically therein.

(a) If the Member receives services at a HMOLA Network Facility with Authorization

When a Member receives inpatient or outpatient services or Emergency Medical Services at a facility that is in the HMOLA Network, it is possible that the Member may receive services from radiologists, anesthesiologists, pathologists, emergency room physicians, hospitalists, intensivists, or other on-call physicians who are not in the HMOLA Network. The Allowable Charge for the services rendered by these Non-Participating Providers will be the same as the Allowable Charge established for these same types of providers who are in the HMOLA Network. This amount is the Non-Participating Provider's Allowable Charge and it is used to determine the amount that We pay for the Member's Covered Services when the services are rendered by a Non-Participating radiologist, anesthesiologist, pathologist, emergency room physician, hospitalist, intensivist, or other on-call physician at a HMOLA Network facility. Non-Participating radiologists, anesthesiologists, pathologists, emergency room physicians, hospitalists, intensivists, or other on-call physicians may bill the Member for the difference between Our payment and the billed charge. Our payment will be Network Benefits.

(b) If the Member receives services at a Non-Participating Facility with Authorization

When a Member receives inpatient or outpatient services or Emergency Medical Care at a facility that is not in the HMOLA Network, it is possible that services may be rendered by Non-Participating Providers who are radiologists, anesthesiologists, pathologists or emergency room physicians. Our Allowable Charge for services rendered by these Non-Participating radiologists, anesthesiologists, pathologists and emergency room physicians will be the

lesser of the provider's billed charge or an amount We negotiate for the services rendered. This amount is the Non-Participating Provider's Allowable Charge and it is used to determine the amount that We pay for the Member's Covered Services by these providers when We either approve the Member to use a Non-Participating Provider facility or when the Member receives Emergency Medical Services at a Non-Participating Provider facility. Our payment will be Network Benefits.

(c) If the Member receives non-transplant services at any Facility without Authorization

If a Member receives inpatient or outpatient services at any facility without obtaining an Authorization, it is possible that services may be rendered by radiologists, anesthesiologists, pathologists, emergency room physicians, hospitalists, intensivists, or other on-call physicians who may or may not be in the HMOLA Network. Our Allowable Charge for services rendered by these Physicians will be as described in paragraphs (a) and (b) above. Network Benefits will be paid for Emergencies as no Authorization is required. Non-Participating radiologists, anesthesiologists, pathologists, emergency room physicians, hospitalists, intensivists, or other on-call physicians may bill the Member for the difference between Our payment and the billed charge.

ILLUSTRATION

The following is an example of the foregoing section.

A Member has this Point of Service plan with a \$15 Copayment. The Non-Network Benefits are 70% - 30% coinsurance with a Deductible. Assume the Member has met his Deductible and has obtained an Authorization for the service. The billed charge for the Covered Service that the Member receives from a Non-Participating Provider who is a radiologist, anesthesiologist, pathologist, emergency room physician, hospitalists, intensivists, or other on-call physicians is \$300. We have negotiated an Allowable Charge of \$100 with HMOLA Network Providers for this service.

The Member receives Covered Services from:	Non-Participating Provider at a Network Facility	Non-Participating Provider at a Non-Participating Facility With Our Authorization	Non-Participating Provider at a Non-Participating Facility Without Our Authorization
Billed for Covered Service:	\$300	\$300	\$300
Allowable Charge:	\$100	irrelevant	\$100
The Member pays:	\$15 (Member's Copayment)	\$15 (Member's Copayment)	30% x \$100 (\$30)
We pay:	\$85 (Allowable Charge less Copayment)	\$285 (Billed Charge less Copayment)	70% x \$100 (\$70)
Will the Member be Billed for the balance?:	YES	NO	YES
TOTAL MEMBER PAYS:	\$215 \$15 Copayment plus the \$200 difference between the \$300 billed charge and the \$100 Allowable Charge.	\$15	\$230 \$30 (\$100 x 30%) plus the \$200 difference between the \$300 billed charge and the \$100 Allowable Charge.

**HOW WE DETERMINE WHAT WE PAY FOR
DEPENDENT OUT-OF-AREA BENEFITS FOR COVERED SERVICES**

- (1) The Subscriber's Dependent who is regularly located outside of the Subscriber's defined Service Area may elect to receive Dependent Out-of-Area Benefits under this Benefit Plan. A Dependent who has elected Out-of-Area Benefits may receive care from a HMOLA Network Provider in any of the service areas in this state. HMOLA Network Providers have agreed to accept the lesser of billed charges or the amount We have negotiated as payment in full for Covered Services provided to the Member in the service area in which the services were provided. This amount is the HMOLA Provider's Allowable Charge and it is used to determine Our payment for the Member's Covered Services.
- (2) A Dependent who has elected Out-of-Area Benefits may receive care from a Participating Provider. Participating Providers are Providers that have not signed contracts with Us, but have signed contracts with Our parent company, Blue Cross and Blue Shield of Louisiana, or another Blue Cross plan, to participate in its Provider networks. These Providers have agreed to accept the lesser of billed charges or an amount We have negotiated as payment in full for Covered Services provided to the Member. This amount is the Participating Provider's Allowable Charge and it is used to determine Our payment for the Member's Covered Services and the amount the Member must pay for his Covered Services when the Member uses a Participating Provider.
- (3) A Dependent who has elected Out-of-Area Benefits may receive care from a Non-Participating Provider. Non-Participating Providers are Providers that do not participate in Our network, do not participate in Blue Cross and Blue Shield of Louisiana's networks, or in a network of another Blue Cross plan. We establish an Allowable Charge for Covered Services provided by Non-Participating Providers that is based on the negotiated fee that has been accepted by Participating Providers. The Allowable Charge is used to determine Our payment for the Member's Covered Services and the amount the Member must pay for Covered Services. **However, the Member has the right to file an Appeal with Us to receive Benefits based on a higher Allowable Charge if the Covered Services were received from a Non-Participating Provider who was the only provider available to deliver the Covered Service within a seventy-five (75) mile radius of the Member's home.**

ILLUSTRATION

The following is an example of the foregoing sections.

A Member is enrolled in Dependent Out-of-Area Benefits. The Dependent Out-of-Area Benefits are 80% - 20% coinsurance with a Deductible. Assume the Member has met his Deductible. The billed charge for the Covered Service that the Member receives is \$300. We have negotiated an Allowable Charge of \$100 with HMOLA Network Providers for this service. We have negotiated an Allowable Charge of \$200 with Participating Providers for this service.

The Member receives Covered Services from:	HMOLA Provider	Participating Provider	Non-Participating Provider
Billed for Covered Service:	\$300	\$300	\$300
Allowable Charge:	\$100	\$200	\$200
The Member pays:	\$ 20	\$ 40	20% x \$200 (\$40)
We pay:	\$ 80 (80% x \$100)	\$160 (80% x \$200)	\$160 (80% x \$200)
Will the Member be billed for the balance?:	NO	NO	YES
TOTAL MEMBER PAYS:	\$ 20	\$ 40	\$140 \$40 (\$200 x 20%) plus

**the \$100 difference between
\$300 billed charge and the
\$200 Allowable Charge.**

WHEN A MEMBER PURCHASES COVERED PRESCRIPTION DRUGS

Some pharmacies have contracted with Us or with Our pharmacy benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are “Participating Pharmacies.” The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base Our payment for the Member’s covered Prescription Drugs.

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

WHEN A MEMBER RECEIVES MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE BENEFITS

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

ASSIGNMENT

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

MEMBER INCENTIVES

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

HMO Louisiana, Inc. has consolidated its customer service e-mails into a single, easy-to-remember address: help@bcbsla.com. Customers who need to contact Us may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit www.bcbsla.com and click on “Contact Us,” found at the upper right of every web page.

ARTICLE I.

DEFINITIONS

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

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

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

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

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

Allowable Charge - The lesser of the billed charge or the amount We establish or negotiate as the maximum amount allowed for all Provider services covered under the terms of this Benefit Plan.

Alternative Benefits - Benefits for services not routinely covered under this Benefit Plan but which the Company may agree to provide when it is beneficial both to the Member and to Us.

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

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

Appeal - A request from the Member or his authorized representative to change a previous decision that We made. Examples of issues that qualify as standard appeals include denied Authorizations or claims based on adverse determinations of Medical Necessity.

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

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

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

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

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

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

Benefit Plan - This agreement, including any Applications for Coverage, Schedule of Benefits and amendments/endorsements to this agreement, if any, entitling the Group's employees and their Dependents to Benefits.

Benefit Plan Date - The date upon which We issued this Benefit Plan to the Group.

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

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

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

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

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

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

Coinsurance - The sharing of eligible charges for Covered Services between the Member and Us. The sharing is expressed as a percentage. Once the Member has met any applicable Deductible Amount, the Member's percentage will be applied to the Allowable Charges for Covered Services to determine the Member's financial responsibility. Our percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Complaint - An oral expression of dissatisfaction with Us or with 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, We will determine what conditions will be covered as Congenital Anomalies. In no event will the term Congenital Anomaly include conditions relating to teeth or structures supporting the teeth, except for cleft palate.

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

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

Copayment (Copay) - The amount of charges for a Covered Service, which a Member must pay. The Copayment may be collected directly from a Member by a Primary Care Physician (or other Network Provider) each time a specified Covered Service is rendered.

Cosmetic Surgery - Any operative procedure, treatment or service, or any portion of an operative procedure, treatment or service performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

An operative procedure, treatment or service will not be considered Cosmetic Surgery if that procedure, treatment or service restores bodily function or corrects deformity of a part of the body that has been altered as a result of Accidental Injury, disease or covered Surgery.

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

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

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

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

Deductible Amounts

A. Benefit Period Deductible Amount

1. "Benefit Period Deductible Amount" - The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Member must pay within a Benefit Period when receiving Network, Non-Network and Dependent Out-of-Area Benefits, before Benefits are provided.
2. Network, Non-Network and Dependent Out-of-Area Benefit categories each carry a separate Benefit Period Deductible Amount as shown in the Schedule of Benefits. Any amounts accruing to the Member's Deductible Amount under one category of Benefits will accrue to the required Deductible Amount for all other categories of Benefits to which a Deductible Amount applies.

B. Family Deductible Amount, if shown in the Schedule of Benefits, is the amount shown in the Schedule of Benefits for each category of Benefits to which a Deductible applies. Once a family has met its Family Deductible, this Benefit Plan

starts paying Benefits for all members of the family, regardless of whether each individual has met his/her individual amount. 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/herself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;
- B. takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or
- C. furnishes, supplies, constructs, reproduces, or repairs or offers to furnish, supply, construct, reproduce, or repair prosthetic dentures, bridges, or other substitute for natural teeth to the user or prospective user.

Dependent - A person, other than the Subscriber, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

Dependent Out-of-Area – A Dependent who is regularly located outside of the Subscriber’s defined Service Area and who enrolls for Dependent Out-of-Area Benefits.

Diagnostic Service - Radiology, laboratory, and pathology services and other tests or procedures We recognize 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 a Member’s coverage begins under this Benefit Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 AM on this date.

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

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

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

Emergency - See “Emergency Medical Condition.”

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

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

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

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

Expedited Appeal - Any request concerning an Admission, availability of care, continued stay, or health care service for a

covered person or his authorized representative who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility.

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

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

Grievance - A written expression of dissatisfaction with Us or with Provider services.

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

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

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

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 care, or other specialty care.

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

Independent Review Organization (IRO) - An Independent Review Organization, not affiliated with Us, that conducts external reviews of final adverse determinations.

Infertility - The inability of a couple to conceive after one year of unprotected intercourse.

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

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

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

- A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard

means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);
2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. reference to federal regulations.

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

Lifetime Maximum Benefit - The maximum amount We will pay on a Member's behalf for Covered Services.

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

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

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

Member - A Subscriber or an enrolled Dependent.

Mental Disorder - 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 Louisiana state law at L.R.S. 22:669 (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under seventeen (17) years of age; Rett's Disorder; and Tourette's Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic mental disorders, to be determined by the Company. The definition of Mental Disorder shall be the basis for determining benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

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

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

Network Provider - A Provider that has signed an agreement with Us to participate as a member of the **HMO Louisiana, Inc.** Provider Network. This Provider may also be referred to as an HMOLA or In-Network Provider.

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

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

Non-Network Provider - A Provider who is not a member of the **HMO Louisiana, Inc.** Network. Participating Providers and Non-Participating Providers are Non-Network Providers as they are not contracted with the HMOLA Provider Network.

Occupational Therapy (OT) - The evaluation and treatment of physical injury or disease, cognitive impairments, congenital or developmental disabilities, or the aging process by the use of specific goal directed activities, therapeutic exercises and/or other interventions that alleviate 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 Group, during which a Subscriber and their eligible Dependents may enroll for Benefits under this Benefit Plan.

Open Enrollment Period - Unless otherwise specified in the Schedule of Benefits, the Open Enrollment Period means the thirty (30) day period prior to the beginning of each Plan Year.

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

Out-of-Pocket Amount - The maximum amount of unreimbursable expenses (in addition to any applicable Deductible Amount) that a Member must pay for Covered Services in one Benefit Period.

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

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 or her license at the time and place service is rendered.

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

Pre-Existing Condition - A physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the ninety (90) day period immediately prior to the Enrollment Date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

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

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

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

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

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

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.

Primary Care Physician (PCP) - A Physician who is a Family Practitioner, General Practitioner, Internist, or Pediatrician and who has signed an agreement to participate in the **HMO Louisiana, Inc.** Provider Network.

Private Duty Nursing Services - Services of an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is unrelated to the patient by blood, marriage or adoption. These services must be ordered by the attending Physician and require the technical skills of an R.N. or L.P.N. in shifts of at least eight (8) continuous hours.

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

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

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

- A. **HMOLA Provider** - A Provider that has a signed contract with Us to participate in Our Provider Network. This Provider is also referred to as an HMOLA Provider, Network Provider, or In-Network Provider.
- B. **Participating Provider** - A Provider that does not have a signed contract with HMOLA, but has a signed contract with Our parent company, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan to participate in its Provider networks.
- C. **Non-Participating Provider** - A Provider that does not have a signed contract with HMOLA, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.

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

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

Service Area - Those parishes in Louisiana shown in the **HMO Louisiana, Inc.** Provider Directory, which lists all **HMO Louisiana, Inc.** Network Physicians, Hospitals and Allied Providers in the Service Area.

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

Skilled Nursing Facility or Unit - A facility licensed by the state in which it operates and is other than a nursing home, or a unit within a Hospital that provides:

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

Special Care Unit - A designated Hospital unit which We approve 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 - A Subscriber or Dependent who is entitled to and who requests special enrollment (as described in this Benefit Plan) within thirty (30) days of losing other certain health coverage or acquiring a new Dependent as a result of marriage, birth, adoption or placement of adoption.

Specialist - A Physician who is not practicing in the capacity of a Primary Care Physician.

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

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

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

Surgery -

- A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, incisional and excisional biopsies and other invasive procedures.
- B. The correction of fractures and dislocations.
- C. Pregnancy Care to include vaginal deliveries and caesarean sections.
- D. Usual and related pre-operative and post-operative care.
- E. Other procedures that We define and approve.

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

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

Transplant Acquisition Expense Maximum - The maximum amount We will pay under this Benefit Plan for a donor's medical expenses, for each transplant covered under this Benefit Plan. Non-medical expenses, such as living expenses, are non-Covered expenses.

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 Our Network if a Member requires non-Emergency medical care or a Member requires Urgent Care after a Member's Physician's normal business hours.

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

Utilization Management - Evaluation of necessity, appropriateness and efficiency of the use of health care services, procedures and facilities.

Waiting Period - see "Eligibility Waiting Period."

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

ARTICLE II.

SCHEDULE OF ELIGIBILITY

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

A. Eligibility

1. Subscriber. To be eligible to enroll as a Subscriber, an individual must reside in the **HMO Louisiana, Inc.** Service Area and must be:
 - a. an employee who has satisfied any criteria designated by Us, has satisfied any Eligibility Waiting Period required by the Group, and who is working the number of hours designated by Us in the Application for Group Coverage;
 - b. a retiree who satisfies any criteria designated by Us, and if shown as covered in the Group's Benefit Plan Schedule of Benefits;
 - c. an elected official who satisfies any criteria designated by Us, and if shown as covered in the Group's Benefit Plan Schedule of Benefits;
2. Dependent. To be eligible to enroll as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by Us that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated as outlined in this Benefit Plan:
 - a. SPOUSE: The Subscriber's legal spouse.
 - b. CHILDREN. The Subscriber's unmarried child who is: under twenty-one (21) years of age or, under twenty-five (25) years of age if enrolled in school as a full-time student (based on the school's definition of a full-time student) in a secondary school, college, university, vocational, technical, vocational-technical, or trade school or institute and is one of the following:
 - (1) born of the Subscriber; or
 - (2) legally placed for adoption with the Subscriber; or
 - (3) legally adopted by the Subscriber; or
 - (4) a child for whom the Subscriber or his or her legal spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Subscriber or his or her legal spouse is a court appointed tutor/tutrix; or
 - (5) a Dependent child supported by the Subscriber pursuant to a Qualified Medical Child Support Order; or
 - (6) a stepchild of the Subscriber; or
 - (7) any unmarried grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or
 - (8) the Subscriber's unmarried child or unmarried grandchild in the legal custody of and residing with the Subscriber who is incapable of self-sustaining employment by reason of being mentally or physically disabled prior to attaining either of the limiting ages shown in paragraph entitled CHILDREN ; or
 - (9) the Subscriber's unmarried child under twenty-five (25) years of age while enrolled as a full-time student (based on the school's definition of a full-time student), at a secondary school, accredited college, university, vocational, technical, vocational-technical, or trade school or institute, who depends upon the Subscriber for support and who develops a mental or nervous disorder, condition or problem which a

qualified psychiatrist certifies as rendering the child unable to attend school as a full-time student and from holding self-sustaining employment.

B. Application for Coverage

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

C. Available Classes of Coverage

The following classes of coverage defined below are available subject to the selection of class or classes of coverage by the Group as shown on the application for group coverage. The Group has the right to change the classes of coverage selected when needed by sending a request to change classes to Our underwriting department.

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

D. Effective Date

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

1. If a person is an Eligible Person on the Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, the Group's Benefit Plan Date will be the Effective Date of coverage.
2. If a person becomes an Eligible Person after the Group's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s), and the enrollment form is received by Us within thirty (30) days of the eligibility date, the Effective Date of coverage will be the eligibility date.
3. If an Eligible Person's application for coverage for self or for self and any eligible Dependent(s) is not received by Us within thirty (30) days of the eligibility date or Special Enrollment Period as described below, the request for enrollment will be denied. The Eligible Person shall be eligible to enroll for coverage during the next Open Enrollment Period. If the Eligible Person timely enrolls during the next Open Enrollment Period, the Eligible Person shall be considered a Late Enrollee and subject to the eighteen (18) month Pre-Existing Condition Exclusion Period.
4. If a Dependent is full time student and continues to meet the requirements for Dependents as shown in the Schedule of Eligibility, the Dependent is eligible to enroll for coverage under this Benefit Plan. The request for enrollment must be received by Us within ninety (90) days of the date the school term begins. If the request is received by Us within ninety (90) days of the date the school term begins, coverage will begin on the first billing date after the

semester begins and the subscriber will be responsible for any additional premium due to any associated enrollment class change. If the request is not received by Us within ninety (90) days of the date the school term begins, the request for enrollment will be denied. The Dependent shall be eligible to enroll for coverage during the next Open Enrollment Period if he continues to meet the requirements for Dependents as shown in the Schedule of Eligibility. If the Dependent timely enrolls during the next Open Enrollment Period, the Dependent shall be considered a Late Enrollee and subject to the eighteen (18) month Pre-Existing Condition Exclusion Period.

5. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), and the enrollment form is received by the Company within one hundred and eighty (180) days of the date of birth, the Effective Date of coverage will be the date of birth.

E. Court Ordered Determination

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

F. Special Enrollment

1. Special Enrollment Due to Loss of Certain Other Coverage

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

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

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

- a. The Eligible Person must be eligible for coverage under the terms of this Benefit Plan;
- b. The Eligible Person must have declined enrollment under this Benefit Plan when offered;
- c. The Eligible Person lost coverage under a plan considered to be Creditable Coverage for HIPAA Portability purposes;
- d. The Eligible Person coverage described in c. above:
 - (1) was under a COBRA continuation provision and the COBRA continuation period was exhausted due to one of the following:
 - (a) the full COBRA continuation period was exhausted;
 - (b) the employer or other responsible entity failed to remit required premiums on a timely basis;
 - (c) the individual whose coverage is through a Health Maintenance Organization (HMO), no longer lives, resides or works in the service area the HMO services, whether or not the choice of the individual in the service area, and there is no other COBRA coverage available;
 - (d) the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual; or
 - (2) was not under a COBRA continuation provision and lost other health coverage due to:
 - (a) loss of eligibility for coverage. Loss of eligibility for coverage includes but is not limited to the following:

- (i) loss of eligibility as a result of legal separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the hours of employment;
- (ii) in the case of coverage offered through a Health Maintenance Organization (HMO) in the individual market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual;
- (iii) in the case of coverage offered through an HMO in the group market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual, and no other health coverage is available to the individual;
- (iv) an individual incurs a claim that meets or exceeds a lifetime maximum of all Benefits; or
- (v) a plan no longer offers any Benefits to the class of similarly situated individuals.

(b) termination of employer contributions to the other coverage.

A Special Enrollee under this section must request enrollment for coverage under this Benefit Plan within thirty (30) days after other coverage ends (or after the employer stops contributing toward the other non-COBRA coverage). If such enrollment is received by a HMO Louisiana, Inc. office within thirty (30) days after loss of other coverage, coverage will become effective on the date other coverage is lost. If the enrollment is not received within thirty (30) days of the loss of other coverage, but is received within sixty (60) days of loss of other coverage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if HMO Louisiana, Inc. does not receive the request for enrollment form within sixty (60) days of the loss of other coverage. An Eligible Person whose coverage was not under COBRA has thirty (30) days after a claim is denied due to the operation of a lifetime limit on all benefits to enroll for coverage, and may request special enrollment from the date such claim is denied. An Eligible Person whose coverage was under COBRA has thirty (30) days after the claim is incurred due to the operation of a lifetime limit on all Benefits to enroll for coverage.

2. Special Enrollment of a Dependent Child Due to Loss of Coverage under the Louisiana Children's Health Insurance Program or a Medicaid Program

- a. This Benefit Plan shall provide for a Special Enrollment Period during which a Dependent child, or if not otherwise enrolled, an employee may be enrolled under this Benefit Plan if enrollment for the Dependent child coverage under this Benefit Plan was declined when it was initially offered because the Dependent child was covered under the State Children's Health Insurance Program or a Medicaid Program.
- b. A Special Enrollee under this section must enroll for coverage under this Benefit Plan and such enrollment must be received by a HMO Louisiana, Inc. office within thirty (30) days after loss of coverage under the State Children's Health Insurance Program or a Medicaid Program. Coverage will become effective on the date of the loss of coverage under the State Children's Health Insurance Program or a Medicaid Program, if the enrollment is received within thirty (30) days of the loss of other coverage.
- c. Only current employees or those already participating in the plan have special enrollment rights for a Dependent child when losing coverage under the State Children's Health Insurance Program or a Medicaid Program.

3. Special Enrollment Due to Acquiring a Dependent

- a. This Benefit Plan shall provide for a special enrollment period during which the Dependent of a participating employee, retiree, or elected official may be enrolled on the plan. If not already participating, a current employee or elected official may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period. (Retirees who are not currently participating do not have these special enrollment rights for adding Dependents and may not come on the plan for this reason.)
- b. A person becomes a Dependent of the covered or eligible employee, retiree or elected official through marriage, birth, adoption, or placement for adoption. In the case of the birth, adoption, or placement for adoption of a child, the spouse of the employee, retiree or elected official may be enrolled as a Dependent if he or she is otherwise eligible for coverage.

- c. If the Group offers multiple health plan options, another option may be chosen by the current employee, retiree or elected official for himself and Dependents when special enrollee status applies.
 - d. The Special Enrollment Period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied. If the Eligible Person timely enrolls during the next Open Enrollment Period, the Eligible Person will be considered a Late Enrollee and subject to the eighteen (18) month Pre-Existing Condition Exclusion Period.
 - e. In the case of a birth, adoption, or placement for adoption, a current employee may enroll himself, his spouse and/or the newborn/adopted child. The enrollment must be requested by signing an enrollment form within thirty (30) days after the birth, adoption, or placement for adoption. If the enrollment form is received by a HMO Louisiana, Inc. office within thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth, adoption, or placement for adoption. A Subscriber may enroll an unborn child prior to birth, however, coverage will not be effective until the date of birth. If the enrollment form is not received by Us within thirty (30) days of birth, adoption or placement for adoption, but is received within sixty (60) days of birth, adoption or placement for adoption, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if the enrollment form is not signed within thirty (30) days of the birth, adoption, or placement of adoption. Coverage will not be available if We do not receive the enrollment form within sixty (60) days of birth, adoption, or placement for adoption.
 - f. In the case of marriage, a current employee may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested by signing an enrollment form within thirty (30) days of the marriage. Coverage will become effective on the date of marriage if the enrollment is received by a HMO Louisiana, Inc. office within thirty (30) days of the marriage. If the enrollment form is not received by Us within thirty (30) days of marriage, but is received within sixty (60) days of marriage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if the enrollment form is not signed within thirty (30) days of the marriage. Coverage will not be available if HMO Louisiana, Inc. does not receive the enrollment form within sixty (60) days of marriage.
4. In all special enrollee circumstances, an employee, retiree or elected official must be enrolled in this Benefit Plan in order for his/her Dependent(s) to be enrolled.

G. Pre-Existing Condition Exclusion Period

Services for Pre-Existing Conditions may not be covered for a certain exclusionary time period, as specified in the Limitations and Exclusions article of this Benefit Plan. However, if a Member has Creditable Coverage and has not experienced a break in coverage of at least sixty-three (63) days prior to the Member's Enrollment Date under this Benefit Plan, credit will be given for time served toward any exclusionary time period under the prior health care plan. If a Member was not covered under a prior health care plan during the sixty-three (63) day period prior to his Enrollment Date under this Benefit Plan, the Member is subject to the Pre-Existing Condition Exclusion Period, as per the Limitations and Exclusions article of this Benefit Plan, unless the following paragraph applies.

Creditable coverage before a sixty-three (63) day break in coverage is counted for certain individuals who elected COBRA coverage under a special second COBRA election period. The special second COBRA election period is available to certain employees who have been affected by import competition or shifts abroad of production capacity and who are receiving trade adjustment assistance under the Trade Act of 2002. If the Member qualifies or may qualify for assistance under the Trade Act of 2002, the Member should contact the Group for additional information.

The Subscriber's Enrollment Date and that of any of the Subscriber's Dependents into the Subscriber's Group health plan is needed to administer any applicable Pre-Existing Condition exclusion provision. If the Subscriber's Group health plan has switched carriers or administrators, We may not have received this enrollment information timely. In order to avoid delays in setting up coverage with Us, the following guidelines are used to establish the Enrollment Date for Members that were insured under their Group's prior health plan and who are moving with the Group as it becomes insured or administered by HMO Louisiana, Inc.

Unless otherwise indicated by the plan or the Subscriber, the Enrollment Date into the Group health plan for all Members insured with the previous carrier will be the Subscriber's hire date. If no hire date is provided, we will not delay the Member's enrollment, but will assign the Group's effective date as the Member's Enrollment Date into the Group health plan. If the Member was not insured by the previous carrier because he/she was serving the plan's Eligibility Waiting Period, the Member's Enrollment Date will be the Subscriber's hire date.

If the plan did not have a carrier or administrator prior to enrolling with Us, the Member's Enrollment Date into this health plan will be the Group's effective date.

For Members who enroll subsequent to the date the Group becomes effective with Us, the subsequent Member's Enrollment Date will be either the Subscriber's hire date or the Member's Effective Date of coverage into the Group plan. This Enrollment Date depends whether the Member is enrolling initially when the Subscriber is hired, or as a Special or Late Enrollee.

ARTICLE III.

BENEFITS PROVIDED

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. The **HMO Louisiana, Inc.** Point of Service Benefit Plan includes the following categories of Benefits:
 - a. **Network Benefits** - Benefits for Covered Services received from a Network Provider. When a Member receives care from a Network Provider, he will receive the highest level of Benefits on this plan.
 - b. **Non-Network Benefits.**
 - (1) Benefits received from a Provider who is not contracted with HMO Louisiana, Inc. When a Member receives care from a Non-Network Provider, he will receive a lower level of Benefits on the plan.
 - c. **Dependent Out-of-Area Benefits** - Benefits for Covered Services provided to the Subscriber's Dependents who are regularly located outside of the Subscriber's defined Service Area and who enroll for Dependent Out-of-Area Benefits.

NOTE: No Benefits are available for Organ, Tissue and Bone Marrow Transplants or evaluations if Authorization is not received prior to services being rendered

Additionally, Network Benefits paid by Us to an HMO Network Provider may be reduced for the Provider's failure to obtain prior Authorization from Us when required to do so. Refer to the Authorization of Services and Supplies section of this Benefit Plan and the Schedule of Benefits for additional information.

2. **Network Benefits**
 - a. The Member must pay all Copayments, Deductible Amounts, and applicable Coinsurance percentages shown in the Schedule of Benefits for a specified Covered Service each time the Covered Service is rendered, subject to any limitations or maximum Benefits shown. These amounts are subject to change from time to time.

3. **Non-Network and Dependent Out-of-Area Benefits**

After any Deductible Amounts shown in the Schedule of Benefits have been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, We will provide Benefits in the Coinsurance percentages shown in the Schedule of Benefits toward Allowable Charges for Covered Services rendered to a Member during a Benefit Period. Our actual payment to a Provider or payment to the Member satisfies Our obligation to provide Benefits under this Benefit Plan. Deductible Amounts, Copayments and Coinsurance percentages are subject to change from time to time

4. **Out-of-Pocket Amount - Network, Non-Network, and Dependent Out-of-Area Benefits**

- a. There is an Out-of-Pocket Amount which the Member must pay for Covered Services in one (1) Benefit Period. After the Member has met the Out-of-Pocket Amount, We will pay one hundred percent (100%) of the Allowable Charges for those Covered Services that accrue to the Out-of-Pocket Amount, unless shown in the Schedule of Benefits. The following expenses accrue toward the Out-of-Pocket Amount, except those for Mental Disorders, alcohol and/or drug abuse, unless otherwise shown in the Schedule of Benefits:
 - (1) any Coinsurance amounts, except those for Mental Disorders, alcohol and/or drug abuse, or Prescription Drug Deductible Amount or Coinsurance Amount, if shown as covered in the Schedule of Benefits;
 - (2) Hospital Inpatient Copayments; and
 - (3) any Outpatient Surgery facility Copayments.
- b. The following do not apply toward satisfying the Out-of-Pocket Amount of this Benefit Plan:
 - (1) Deductible Amounts;
 - (2) any charges in excess of the Allowable Charge;
 - (3) amounts the Member or Provider must pay due to failure to obtain any Authorization required under this Benefit Plan;
 - (4) Copayments that the Member pays other than Inpatient Hospital Copayment and Outpatient Surgery facility Copayments;
 - (5) charges for non-Covered Services; and/or
- c. The following do not apply toward satisfying the Out-of-Pocket Amount of this Benefit Plan, unless shown on the Schedule of Benefits:
 - (1) expenses the Member must pay when those expenses are incurred for the treatment and care for Mental Disorders; and/or
 - (2) expenses the Member must pay when those expenses are incurred for the treatment and care for alcohol and/or drug abuse.

B. Deductible Carryover

The Allowable Charges incurred for Covered Services during the months of October, November and December which were applied toward the Benefit Period Deductible Amount, but did not satisfy the Benefit Period Deductible Amount, may be applied to the Member's Benefit Period Deductible Amount for the next calendar year. If the Deductible Amount is met or exceeded, this deductible carryover feature is not available. This carryover feature applies to the Benefit Period Deductible Amount only. It does not apply to Prescription Drug Deductible Amount, Family Deductible Amount or any other type of deductible described in this Benefit Plan.

C. Lifetime Maximum Benefit

The Lifetime Maximum Benefit available to the Subscriber and his Dependents, if any, will be as shown in the Schedule of Benefits. The Lifetime Maximum Benefit means the maximum amount We will pay on behalf of a Member for Covered Services.

D. Deductible Amount

We will apply the Member's Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Member, then when the Member receives Covered Services from another Provider, that Provider also collects the Member's Deductible Amount. This generally occurs when the Member's Claims have not been received and processed by Us. Our system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Member may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If

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

F. Accumulator Transfers

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

ARTICLE IV.

HOSPITAL BENEFITS

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

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Member requiring an intensive level of care.
3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital, for the maximum number of days per Benefit Period shown in the Schedule of Benefits.
4. In a Residential Treatment Center for Members with Mental Disorders and Alcohol and/or Drug Abuse Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

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

C. Emergency Room Benefits

1. Network Benefits: The Member must pay an Emergency Room Copayment, as shown in the Schedule of Benefits, for each visit to an Emergency Room for treatment. The Emergency Room Copayment is waived if the visit results in an Inpatient Admission.
2. Non-Network and Dependent Out-of-Area Benefits: The Member must pay any applicable Deductible Amount and Coinsurance percentage, subject to any limitations or maximum Benefits shown in the Schedule of Benefits.

D. Pre-Admission Testing Benefits

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

ARTICLE V. SURGICAL AND MEDICAL 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 Us 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 Us.

- (2) The Allowable Charge includes the rebundled procedure. We will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as We determine.

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 for 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 nurse anesthetist or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by Us. Supervision of anesthesia administration includes pre-operative, operative and post-operative supervision of anesthesia administration care.
- b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless We determine otherwise.
- c. Benefits for anesthesia will be determined by applying Our Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Our payment may be divided between the supervision and administration of anesthesia when billed separately.

5. Second Surgical Opinion

Second surgical opinions are covered, subject to any applicable Copayments, Coinsurance and Deductible Amounts, but are not mandatory in order to receive Benefits.

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

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

C. Outpatient Medical and Surgical Services

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

D. Breast Reconstructive Surgical Services

1. If a Member is receiving Benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy, the Member will also receive benefits for the following Covered Services:
 - a. reconstruction of the breast on which the mastectomy has been performed;

- b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.
2. These Covered Services shall be delivered in a manner determined in consultation with the Member and the Member's attending Physician, if applicable, and will be subject to any Deductible Amounts, Copayments and Coinsurance.

ARTICLE VI. PREVENTIVE OR WELLNESS CARE

A. Well Woman Examinations - Network Benefits, Non-Network and Dependent Out-of-Area Benefits:

- 1. Two (2) visits per Benefit Period to an obstetrician/gynecologist for a routine gynecological exam.

The Member may schedule follow-up visits within sixty (60) days of a routine gynecological exam for treatment of a condition that was diagnosed or treated during a routine gynecological exam.
- 2. One (1) routine Pap Smear per Benefit Period. The Deductible Amount does not apply.
- 3. One (1) Mammography examination every twelve (12) months, or more frequently if recommended by the Member's Physician. The Deductible Amount does not apply.

B. Physical Examinations - Network Benefits and Dependent Out-of-Area Benefits:

- 1. One (1) routine physical examination per Benefit Period, including related diagnostic tests performed during the same visit.
- 2. Well Baby Care.

C. Immunizations - Network Benefits, Non-Network Benefits, and Dependent Out-of-Area Benefits:

- 1. All state-mandated immunizations including the complete basic immunization series as defined by the state health officer and required for school entry for children up to age six (6). The Deductible Amount does not apply.
- 2. Immunizations recommended by the Member's Physician. The Deductible Amount does not apply.

D. Other Wellness Services - Network Benefits, Non-Network Benefits and Dependent Out-of-Area Benefits

- 1. Digital rectal examination and prostate-specific antigen (PSA) test limited to one (1) per Benefit Period, is covered for Members, fifty (50) years of age or older, and as recommended by his Primary Care Physician if the Member is over forty (40) years of age.

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

The Deductible Amount does not apply.

- 2. Hemoccult (colon) test, limited to one (1) per Benefit Period.
- 3. Specific Preventive or Wellness Care services may be included or excluded from this Benefit if shown in the Schedule of Benefits.

ARTICLE VII. PREGNANCY CARE BENEFITS

Coverage is available for Pregnancy Care only if shown as covered in the Schedule of Benefits. If Pregnancy Care is not covered, complications of pregnancy are not covered, except for ectopic pregnancies and spontaneous abortions (miscarriages). Benefits for ectopic pregnancies and spontaneous abortions (miscarriages) are available for all covered Members under Articles IV and V of this Benefit Plan the same as any other Covered Service, and are not subject to this Article.

If Pregnancy Care is covered, Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a patient covered as a Subscriber or Dependent wife of a Subscriber whose coverage is in effect at the time such services are furnished in connection with her pregnancy. An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child **only if** the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. 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.

Pregnancy Care Benefits are as follows:

A. Surgical and Medical Services

1. Initial office visit and visits during the term of the pregnancy.
2. Diagnostic Services.
3. Delivery, including necessary pre-natal and post-natal care.
4. Medically Necessary abortion required in order to save the life of the mother.

B. Facility Services

Hospital services required in connection with pregnancy and Medically Necessary abortions as described above are covered. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care.

C. Benefits

1. Network Benefits: A Pregnancy Care Copayment, if shown in the Schedule of Benefits, applies to each pregnancy for Covered Services rendered by Network Providers. The Member must pay an Inpatient Hospital Admission Copayment for any hospitalization related to the pregnancy, as shown in the Schedule of Benefits, in addition to the Pregnancy Care Copayment. An In-Network Deductible and Coinsurance may apply to some plans, if shown in the Schedule of Benefits.
2. Non-Network and Dependent Out-of-Area Benefits: The Member must pay the Inpatient Hospital Admission Coinsurance and Pregnancy Care Coinsurance if shown in the Schedule of Benefits, in addition to the applicable Deductible Amount. A Non-Network and Dependent Out-of-Area Deductible and Coinsurance may apply to some plans, if shown in the Schedule of Benefits.

ARTICLE VIII.

NEWBORN CARE

For a newborn who is covered at birth as a Dependent:

- A. Surgical and medical services rendered by a Physician, for treatment of illness, prematurity, postmaturity, 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 and Dependent Out-of-Area Benefit Categories only.
1. Network Benefits: The Member must pay all applicable Deductibles, Coinsurance and Copayments as shown in the Schedule of Benefits.
 2. Non-Network and Dependent Out-of-Area Benefits: Benefits for services of a Physician for treatment of a newborn will be determined by applying any applicable Deductible and Coinsurance to Allowable Charges for Covered Services.
- B. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, prematurity, postmaturity, or congenital condition of a newborn. Charges for a well newborn which are billed separately from the mother's Hospital bill are not covered.

1. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care.
2. Network Benefits: An Inpatient Hospital Admission Copayment applies to the Admission of an ill newborn for treatment in a Hospital. We will provide Benefits of one hundred percent (100%) of the Allowable Charges for such treatment, less the Member's Copayment. An In-Network Deductible and Coinsurance may apply to some plans, if shown in the Schedule of Benefits.
3. Non-Network and Dependent Out-of-Area Benefits: Benefits for Hospital Covered Services for treatment of an ill newborn will be determined by applying the Coinsurance shown in the Schedule of Benefits to Allowable Charges for those services. A Non-Network and Dependent Out-of -Area Deductible and Coinsurance may apply to some plans, if shown in the Schedule of Benefits.

ARTICLE IX.

REHABILITATIVE CARE BENEFITS

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

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

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

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

A. Occupational Therapy Benefits

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. Occupational Therapy is not covered when maintenance level of therapy is attained.
2. Occupational Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.
3. Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.

B. Physical Therapy Benefits

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license. Physical Therapy is not covered when maintenance level of therapy is attained.
2. Physical Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.
3. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.
4. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the

receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances and if Benefits are provided for the following:

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

C. Speech/Language Pathology Therapy Benefits

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, licensed to practice in the state in which services are rendered.
2. The therapy must be used to improve or restore speech language deficits or swallowing deficits.
3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to the receipt of services.

D. Chiropractic Services Benefits

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 Member'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 X.

PRESCRIPTION DRUG BENEFITS

- A. Coverage is available for Prescription Drugs if shown as covered on the Schedule of Benefits. The Prescription Drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that We determine and only those Prescription Drugs that We determine are Medically Necessary will be covered. Certain Prescription Drugs may be subject to Step Therapy or require prior Authorization as shown on the Schedule of Benefits.
- B. Prescription Drugs dispensed at retail or through the mail are subject to the Prescription Drug Copayment or Coinsurance Amount and any applicable Prescription Drug Deductible Amount shown on the Schedule of Benefits. The Member may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Member may be required to pay a different Copayment or Coinsurance depending on whether the Member's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.
- C. If a Prescription Drug Deductible Amount is applicable, this amount must be satisfied prior to any applicable Prescription Drug Copayment or Coinsurance. The Prescription Drug Deductible Amount is separate from the Benefit Period

Deductible Amount and do not accrue to the satisfaction of the Out-of-Pocket Amount.

- D. Prescription Drug Copayments and Coinsurance are based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on Our evaluation of a particular medication's clinical efficiency, safety, cost, and pharmacoeconomic factors.
1. Tier 1 – A Prescription Drug that is a Generic Drug or a Brand-Name Drug.
 2. Tier 2 – A Prescription Drug that is a Brand-Name Drug or a Generic Drug.
 3. Tier 3 – A Prescription Drug that is a Brand-Name Drug or a Generic Drug that may have a therapeutic alternative as a Tier 1 or Tier 2 drug. Covered compounded drugs are included in this Tier.
 4. Tier 4 – A Prescription Drug that is a Multi-Source Brand Drug.
 5. Tier 5 – Injectable Prescription Drugs include those medications that are intended to be self-administered. However, insulin and injectable antihemophilic Prescription Drugs may be included in another drug tier.
- E. Necessary insulin syringes and test strips are covered under the Prescription Drug benefit.
- F. The Member can view Our Blue Selections Rx Member Guide on Our website at www.bcbsla.com or request a copy by mail by calling Our pharmacy benefit manager at the telephone number indicated on the Member's ID card.

G. Drug Utilization Management Program

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

1. Prior Authorization – As part of Our Drug Utilization Management program, Members and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on our website at www.bcbsla.com or by calling the customer service telephone number on the Member's ID Card. If the Prescription Drug requires prior Authorization, the Member's Physician must call the medical Authorization telephone number on the Member's ID Card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.
 2. Safety checks – Before the Member's prescription is filled, Our pharmacy benefit manager or We perform quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g. refill prior to seventy-five (75%) day supply used).
 3. Quantity Per Dispensing Limits/Allowances – Prescription Drugs selected by Us are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity Per Dispensing Limits/Allowances are based on the following: (a) the manufacturer's recommended dosage and duration of therapy; (b) common usage for episodic or intermittent treatment; (c) FDA-approved recommendations and/or clinical studies; or (d) as determined by Us.
 4. Step Therapy – In some cases, We may require the Member to first try one Prescription Drug to treat a medical condition before We will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, We may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then We will cover a prescription written for Drug B.
- H. Some pharmacies have contracted with Us or with Our pharmacy benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base Our payment for the Member's Covered Prescription Drugs.

- I. When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our pharmacy benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that it dispenses, the Allowable Charge is the negotiated amount that Participating Pharmacies have agreed to accept for drugs dispensed.
- J. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Member should submit claims on Our Prescription Drug claim form. For information on how to file claims for foreign Prescription Drug purchases the Member should contact Us or Our pharmacy benefit manager at the telephone number indicated on the Member's ID card.
- K. As part of Our administration of Prescription Drug benefits, We may disclose information about a Member's Prescription Drug utilization, including the names of the Member's prescribing Physicians, to any treating Physicians or dispensing pharmacies.
- L. Any savings or rebates We receive on the cost of drugs purchased under this Benefit Plan from drug manufacturers are used to stabilize rates.

ARTICLE XI. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

A. Ambulance Service Benefits

- 1. The following Ambulance Services for local transportation are covered when Medically Necessary:
 - a. to or from the nearest Hospital that can provide services appropriate to a Member's condition for an illness or injury requiring Hospital care;
 - b. to the nearest Hospital or neonatal Special Care Unit for newborn infants for treatment of illnesses, injuries, congenital birth defects and complications of premature birth which require that level of care;
 - c. for the Temporarily Medically-Disabled Mother of the ill Newly-Born Infant when accompanying the ill Newly-Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.
- 2. Benefits for air Ambulance Services are available only if this type of Ambulance Service is requested by policing or medical authorities at the site in an Emergency situation or if the Member is in a location that cannot be reached by a ground ambulance.
- 3. In a non-Emergency situation, air Ambulance Service is not covered unless the Member requests and receives Authorization from Us prior to the service being rendered.
- 4. If a Member pays a periodic fee to an ambulance membership organization with which We do not have a Provider Agreement, Benefits for expenses that the Member incurs for Ambulance Services will be based on any obligation the Member must pay that is not covered by the fee.
- 5. No Benefits are available if transportation is provided for the Member's comfort or convenience, or when a Hospital transports Members between parts of its own campus.

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered at the Coinsurance percentages shown in the Schedule of Benefits. Durable Medical Equipment, Orthotic Devices and Non-Limb Prosthetic Appliances and Devices and Prosthetic Services are subject to an aggregate Benefit Period maximum, if shown in the Schedule of Benefits. Prosthetic Appliances and Devices of the limbs and Prosthetic Services of the limbs accrue to the Benefit Period maximum for each limb, shown in the Schedule of Benefits.

- 1. Durable Medical Equipment

- a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be provided mainly for the comfort or convenience of the Member or others. In addition, the equipment must meet all of the following criteria:
 - (1) It must withstand repeated use,
 - (2) It must be primarily and customarily used to serve a medical purpose,
 - (3) It must be generally not useful to a person in the absence of illness or injury, and
 - (4) It must be 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 Our rental Allowable Charge (but not to exceed the purchase Allowable Charge).
 - (2) At Our option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use.
 - (3) Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Member selects deluxe equipment solely for his comfort or convenience.
 - (4) Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
 - (5) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.
 - (6) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or damaged due to neglect or misuse or for replacement of equipment within five (5) years of purchase or rental will not be covered.
- c. Limitations in connection with Durable Medical Equipment.
 - (1) There is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.
 - (2) There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.
 - (3) There is no coverage for the repair or replacement of equipment lost or damaged due to neglect or misuse.
 - (4) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by Us.

2. Orthotic Devices

Benefits as specified in this section will be available for the purchase of Orthotic Devices and will be subject to the following:

- a. There is no coverage for fitting or adjustments as this is included in the Allowable Charge for the Orthotic Device.
- b. Repair or replacement of the Orthotic Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. We will determine this time period.
- c. Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when the Member selects a deluxe device solely for his comfort or convenience.

- d. Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented to be Medically Necessary.
- e. No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

Benefits will be available for the purchase of Prosthetic Appliances and Devices (other than limb prosthetics and services) that We Authorize, 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 after a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time period.
- c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when the Member selects a deluxe appliance solely for his comfort or convenience.
- d. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.

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

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

- a. All Prosthetic Appliances and Devices and Prosthetic Services for limbs accrue to the Benefit Period maximum for each limb, shown in the Schedule of Benefits.
- 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. We will determine this time period.
- c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Member selects a deluxe appliance solely for his comfort or convenience. A Member may choose a Prosthetic Appliance or Device that is priced higher than the benefit payable under this Benefit Plan and may pay the difference between the price of the device and the benefit payable, without financial or contractual penalty to the provider of the device.
- d. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.
- e. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

C. Private Duty Nursing Services

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

D. Vision Care - All Benefit Categories

1. One (1) routine eye examination as shown in the Schedule of Benefits.
2. A Member must pay the Vision Care Copayment shown in the Schedule of Benefits.
3. Benefits may be available for glasses or contact lenses if shown as a Covered Service in the Schedule of Benefits, and are subject to any limitation shown.

E. Out-of-Area Emergency Medical Services

1. A Member must pay an emergency room Copayment, Deductible and/or Coinsurance shown in the Schedule of Benefits, for each visit the Member makes to a Hospital or Allied Health Facility for Emergency Medical Services while outside his Service Area.
2. The emergency room Copayment is waived if the visit results in an Inpatient Hospital Admission.
3. A Member must pay a Physician's Copayment for each visit the Member makes to a Physician's office for Emergency Medical Services while outside his Service Area.

F. Disposable Medical Equipment or Supplies

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

G. Cleft Lip and Cleft Palate Services

Covered Services include the following:

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

H. Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder when rendered or prescribed by a Physician or Allied Health Professional is covered. However, the maximum We will pay is the following:

1. Six hundred dollars (\$600.00) for initial diagnosis;
2. Two thousand five hundred dollars (\$2,500.00) per Benefit Period;
3. Ten thousand dollars (\$10,000.00) total lifetime Benefits.

A Member must pay the Copayment, Deductible and/or Coinsurance applicable to the type of Provider rendering services for this condition. The Member is responsible for all amounts in excess of the above. Charges in excess of the above are non-covered charges and do not accrue to the Member's Out-of-Pocket Amount.

I. Coverage for Diabetes

1. Coverage is available for the equipment, supplies, and Outpatient self-treatment training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Member's Physician.
2. A one time evaluation and training program per Member for diabetes self-management is covered, subject to the following:
 - a. The program must be determined to be Medically Necessary by a Physician and provided by a licensed health care professional that certifies that a Member has successfully completed the training program.
 - b. The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.
 - c. The Benefits provided for the training program will not exceed five hundred dollars (\$500.00).
3. Additional diabetes self-management training is covered subject to the following:
 - a. A Physician prescribes additional training based upon Medical Necessity because of a significant change in the Member's symptoms or conditions.
 - b. Additional coverage is limited to one hundred dollars (\$100.00) per year and a lifetime limit of two thousand dollars (\$2,000.00) per Member.

The Member is responsible for all amounts in excess of the above. Charges in excess of the above are non-covered charges and do not accrue to the Member's Out-of-Pocket Amount.

J. Interpreter Expenses for the Hearing Impaired

Services performed by a qualified interpreter/transliterators are covered when the Member needs such services in connection with medical treatment or diagnostic Consultations performed by a Physician or Allied Health Professional, if the services are required because of the Member's hearing impairment or his failure to understand or otherwise communicate in spoken language. Services rendered by a family member are not covered.

K. Clinical Trial Participation

1. Patient costs are covered when incurred for treatment provided in a clinical trial for cancer, as described in this paragraph. Coverage will be subject to any applicable Copayment, Deductible, and/or Coinsurance amounts shown in the Schedule of Benefits.
2. 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. Investigational drugs or devices; and/or
 - d. Services, treatment or supplies not otherwise covered under this Benefit Plan.
3. Investigational treatments and associated protocol related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:
 - a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.

- b. The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.
- c. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
 - (1) One of the United States National Institutes of Health.
 - (2) A cooperative group funded by one of the National Institutes of Health.
 - (3) The FDA, in the form of an investigational new drug application.
 - (4) The United States Department of Veterans Affairs.
 - (5) The United States Department of Defense.
 - (6) A federally funded general clinical research center.
 - (7) The Coalition of National Cancer Cooperative Groups.
- d. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.
- e. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
- f. There must be no clearly superior, non-investigational approach.
- g. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.
- h. The patient has signed an institutional review board approved consent form.

L. Bone Mass Measurement

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

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

M. Urgent Care Center Benefits

Services of Urgent Care Centers are covered.

N. Hospice and Home Health Care Benefits

- 1. Hospice Care is covered up to the maximum number of days per Benefit Period shown in the Schedule of Benefits.
- 2. Home Health Care services provided to a Member in lieu of an Inpatient Hospital Admission are covered, for the maximum number of visits per Benefit Period shown in the Schedule of Benefits.

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

Benefits are available for low protein food products for treatment of certain Inherited Metabolic Diseases. “Inherited

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

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

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

Benefits shall not exceed two-hundred (\$200.00) per month, and are subject to applicable Deductible Amounts, Coinsurance, and/or Copayments as shown on the Schedule of Benefits. The Member is responsible for all amounts above two-hundred (\$200.00) per month. Charges over two-hundred (\$200.00) per month are non-covered charges and do not accrue to the Member’s Out-of-Pocket Amount.

P. Hearing Aids

Benefits are available for hearing aids for covered Members age seventeen (17) and under. This Benefit is limited to one (1) hearing aid, per ear, in a thirty-six (36) month period. The hearing aid must be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

We will pay up to one thousand four hundred dollars (\$1,400.00) per hearing aid, per ear, in a thirty-six (36) month period. If the Member purchases a hearing aid that costs more than one thousand four hundred dollars (\$1,400.00), the Member is responsible for all amounts above one thousand four hundred dollars (\$1,400.00). This Benefit is not subject to Coinsurance or Deductible Amounts.

Eligible implantable bone conduction hearing aids are not subject to the above limitation and provisions. They are covered the same as any other service or supply, subject to any applicable Copayment, Coinsurance and Deductible Amounts.

Q. Colorectal Cancer Screening Benefits

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

R. Permanent Sterilization Procedures

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

S. Sleep Studies

Medically Necessary sleep studies and associated professional claims are eligible for coverage when a sleep study is obtained in a facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Academy of Sleep Medicine (AASM).

T. Prescription Drugs

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

U. Specialty Pharmacy Program

1. The Specialty Pharmacy Program covers certain drugs commonly referred to as high-cost Specialty Drugs. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through a select group of contracted specialty pharmacies. These pharmacies comprise the "Specialty Pharmacy Network." The Specialty Pharmacy Network specializes in dispensing and delivering drugs that require special handling. Specialty pharmacies provide additional helpful services, such as courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the Specialty Drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis. The Member may contact Our Customer Service Department, or access www.bcbsla.com/pharmacy, to identify the drugs contained on the Specialty Drug list. Members may also access the website or contact Our Customer Service Department for assistance in locating the network specialty pharmacy that can be used to obtain medication.
2. Specialty pharmacy that are included in Our Specialty Pharmacy Network have contracted with Us or with Our pharmacy benefit manager to accept a negotiated amount as payment in full for the covered Specialty Drugs that they dispense. Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Specialty Drugs purchased from the Specialty Pharmacy Network is the negotiated amount and it is used to base Our payment for the Member's Covered Specialty Drugs. When the Member purchases covered Specialty Drugs from a pharmacy that has not contracted with Us or with Our pharmacy benefit manager through Our Specialty Pharmacy Program to accept a negotiated amount as payment in full for the covered Specialty Drugs that it dispenses, the Allowable Charge is the negotiated amount that specialty pharmacies have agreed to accept for drugs dispensed.

S. Dietician Visits

Benefits are available for outpatient visits to registered dietitians, subject to payment of any applicable Deductible and Coinsurance shown on the Schedule of Benefits. Benefits are limited to a specific dollar amount of Allowable Charges per Benefit Period. The Member will be responsible for all amounts in excess of the amount shown on the Schedule of Benefits. Charges in excess of this amount are considered Non-Covered Services and will not accrue to the Member's Out-of-Pocket Amount. Dietician visits for diabetics are not covered under this benefit. Dietician visits for diabetics may be available under a separate benefit for diabetes self-treatment training and education.

T. Autism Spectrum Disorders (ASD)

Any and all Benefits related to the diagnosis and treatment of Autism Spectrum Disorders are subject to the ASD Benefit Period Maximum and ASD Lifetime Maximum shown on the Schedule of Benefits. The Member's age at the time the Benefit is obtained determines which Benefit Period Maximum applies. The ASD Benefit Period Maximum accrues to the ASD Lifetime Maximum. The ASD Lifetime Maximum accrues to the overall Lifetime Maximum. ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Members who have not yet reached their seventeenth (17th) birthday are eligible for Applied Behavior Analysis, when Company determines it is Medically Necessary. Applied Behavior Analysis is not covered for Members age seventeen (17) and older.

ASD Benefits are subject to the Co-payments, Deductibles, and Coinsurance amounts that are applicable to the Benefits obtained. (Example: A Member obtains speech therapy for treatment of ASD. Member will pay the applicable Co-Payment, Deductible or Coinsurance amount shown on the Schedule of Benefits for speech therapy. The speech therapy will apply to the ASD Benefit Period Maximum and ASD Lifetime Maximum; it will not apply to any speech therapy maximum shown on the Schedule of Benefits.)

ARTICLE XII. MENTAL DISORDERS, ALCOHOL AND/OR DRUG ABUSE BENEFITS

- A. Benefits for the treatment of Mental Disorders are available subject to any limitations shown in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Coverage for treatment of Mental Disorders does **not** include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
- B. Coverage for treatment of alcohol and/or drug abuse is available only if shown as Covered Services in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. 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.
- C. Covered Services for Inpatient and Outpatient treatment of Mental Disorders and alcohol and/or drug abuse are limited as shown in the Schedule of Benefits.
- D. Two (2) days of Partial Hospitalization Program (PHP) or two (2) days of Residential Treatment Center hospitalization may be traded for each Inpatient day of treatment that is available under the maximum for Inpatient treatment, as shown in the Schedule of Benefits. Partial hospitalization is a level of care where the patient remains in the Hospital less than twenty-four (24) hours.
- E. Each day of treatment in an Intensive Outpatient Program (IOP) will be counted as one (1) Outpatient visit for Benefit purposes.
- F. Network and Non-Network Benefits: Benefits paid for the treatment of Mental Disorders and alcohol and/or drug abuse under Network and Non-Network Benefits will accrue to the Benefit maximums for each Benefit category.
- G. The Member is responsible for payment of applicable Copayments, Coinsurance and/or Deductible Amounts for any substituted Benefit.

ARTICLE XIII. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, providers in the HMO Network and the Blue Cross and Blue Shield of Louisiana Key Dental Network are considered Network Providers. Access both networks online at www.bcbsla.com, or call the customer service telephone number on your ID card for copies of the directories. Coverage is provided only for the following services or procedures:

- A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- B. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.)
- C. Excision of exostoses or tori of the jaws and hard palate.
- D. Incision and drainage of abscess and treatment of cellulitis.
- E. Incision of accessory sinuses, salivary glands, and salivary ducts.
- F. Anesthesia for the above services or procedures when rendered by an oral surgeon.
- G. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- H. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia Benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders.

- I. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To determine if the Member is eligible for these benefits, please call Our Customer Service Unit at the phone number on the Member's ID card, and ask to speak to a Case Manager.

ARTICLE XIV. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS
(Network and Dependent Out-of-Area Categories Only)

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

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

A. Acquisition Expenses

If a solid organ, tissue or bone marrow is obtained from a living donor for a covered transplant, the donor's medical expenses are covered as acquisition costs for the recipient under this Benefit Plan. Benefits for covered acquisition expenses shall accrue to and are limited to the Transplant Acquisition Expense Maximum shown in the Schedule of Benefits regardless of when the expenses are incurred. Donor's medical expenses in excess of the Transplant Acquisition Expense Maximum, if any, may be covered under the donor's policy if the donor is a Member of Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc.

Bone marrow donor search costs shall accrue to the Transplant Acquisition Expense Maximum, shown in the Schedule of Benefits.

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

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) or an HMO Louisiana, Inc. (HMOLA) Network facility, unless otherwise approved by Us in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities. To locate an approved transplant facility, Members should contact Our Customer Service Department at the number listed on their ID card.
2. The Organ, Tissue and Bone Marrow Transplant Benefits are shown in the Schedule of Benefits and are not covered under the Non-Network Benefit category. Benefits are provided for Network services and for Dependent Out-of-Area services.
3. Network and Dependent Out-of-Area Benefits: Benefits that are covered by the Transplant Acquisition Expense Maximum will accrue to the overall Lifetime Maximum Benefit, shown in the Schedule of Benefits, for each Member.
4. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

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

C. Solid human organ transplants of the:

1. Liver;

2. Heart;
3. Lung;
4. Kidney;
5. Pancreas;
6. Small bowel; and
7. Other solid organ transplant procedures, which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case by case basis.

D. Tissue transplant procedures (autologous and allogeneic), as specified below.

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

These following tissue transplants are covered:

1. Blood transfusions;
2. Autologous parathyroid transplants;
3. Corneal transplants;
4. Bone and cartilage grafting;
5. Skin grafting;
6. Autologous islet cell transplants; and
7. Other tissue transplant procedures which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case by case basis.

E. Bone marrow transplants

1. Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.
2. Other bone marrow transplant procedures which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These bone marrow transplant procedures will be considered on a case-by-case basis.

ARTICLE XV. AUTHORIZATION OF SERVICES AND SUPPLIES

A. Authorization, Selection of Provider, and Penalty for Failure to Authorize

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

If a Member wants to receive services from a Non-Network Provider and obtain the highest level of Benefits, he must notify Our Care Management Department before services are rendered. We will approve the use of a Non-Network Provider only if We determine that the services **cannot** be provided by a Network Provider within a seventy-five (75) mile radius of the Member's home. We must approve the use of the Non-Network Provider and issue any required Authorization before services are rendered. If We do not approve the use of the Non-Network Provider and issue an Authorization prior to services being rendered, We will pay Benefits at the lower Non-Network Level as shown on the Schedule of Benefits.

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

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

If Authorization is not requested prior to the Admission, We will have the right to determine if the Admission was Medically Necessary. If the Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the service. If a Network Provider fails to obtain a required Authorization, We will reduce his Benefit payment by the amount shown under the Authorization of Services, Equipment and Supplies section in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization. The Network Provider is responsible for all charges not covered and for the penalty amount. The Member remains responsible for his Copayment, Deductible amount and applicable Coinsurance percentage. If a service was not Medically Necessary, the service is not covered.

B. Authorization of Admissions

1. Authorization of Elective Admissions

- a. The Member is responsible for ensuring that his Provider contacts Our Care Management Department is notified of any Elective or non-Emergency Inpatient Hospital Admission. The Company must be notified (by calling the telephone number shown in the Schedule of Benefits or the Member's ID card) prior to the Admission regarding the nature and purpose of any Elective Admission or non-Emergency Admission to a Hospital's Inpatient department. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.
- b. If a request for Authorization is denied by Us for an Admission to any facility, the Admission is not covered and the Member must pay all charges incurred for Hospital services during the Admission for which Authorization was denied.
- c. If Authorization is not requested prior to the services being rendered, in addition to any Deductible Amount and Coinsurance amount required in this Benefit Plan, the Member will be responsible for all charges for Hospital services not specifically listed as Covered Services during the Admission and for any penalty amount shown in the Schedule of Benefits. Additionally, all days not Authorized will be reviewed for Medical Necessity and could be denied.
- d. Additional amounts for which the Member is responsible because Authorization of an Elective or non-Emergency Inpatient Hospital Admission was denied or not requested will not apply toward satisfying the Out-of-Pocket Amount.

2. Authorization of Emergency Admissions

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

- c. Additional amounts the Member is responsible for because Authorization of an Emergency Admission was denied or not requested will not apply toward the Out-of-Pocket Amount.

3. Concurrent Review

- a. When We Authorize a Member's Inpatient stay, We will Authorize his stay in the Hospital for a certain number of days. If the Member has not been discharged on or before the last Authorized day, and the Member needs additional days to be Authorized, the Member must make sure his Physician or Hospital contacts Our Care Management Department to request Concurrent Review for Authorization of additional days. This request for continued hospitalization must be made on or before the Member's last Authorized day so We can review and respond to the request that day. If We Authorized the request, We will again Authorize a certain number of days, repeating this procedure until the Member is either discharged or the Member's continued stay request is denied.
- b. If We do not receive a request for Authorization for continued stay on or before the Member's last Authorized day, no days are approved past the last Authorized day, and no additional Benefits will be paid unless We receive and Authorize another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and We determine that it is not Medically Necessary for the Member to receive continued hospitalization or hospitalization at the level of care requested, We will notify the Member and his Providers, in writing, that the request is denied and no additional days are Authorized.
- c. If We deny a Concurrent Review request or level of care request for Hospital Services, We will notify the Member, his Physician and the Hospital of the denial. If the Member elects to remain in the Hospital as an inpatient thereafter, or at the same level of care, the Member will not be responsible for any charges unless he is notified of his financial responsibility by the Physician or Hospital in advance of incurring additional charges.
- d. Charges for non-Authorized days in the Hospital that the Member must pay will not apply toward satisfying the Out-of-Pocket Amount.

C. Authorization of Other Covered Services and Supplies

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

D. Appeals

1. If either the Member or the Provider disagrees with the denial of any Authorization, the denial may be appealed as shown in the Compliant, Grievance and Appeals article of this Benefit Plan.

The Member or the Provider may file a first level appeal by contacting Us in writing within one-hundred eighty (180) days of notice of the denial in accordance with the Complaints, Grievance and Appeals article of this Benefit Plan.

2. If We do not reverse the decision, the Member will be responsible for and no Benefits will be payable for charges incurred.
3. Providers will be notified of Appeal results only if the Provider filed the Appeal.

ARTICLE XVI.

DISEASE MANAGEMENT

Qualification

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

Disease Management Benefits

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

ARTICLE XVII. CASE MANAGEMENT

- A. The Member may qualify for Case Management Services, at Our discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.
- B. The role of Case Management is to service the Member by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.
- C. Our determination that a particular Member's medical condition renders the Member a suitable candidate for Case Management services will not obligate Us to make the same or similar determination for the Member or for any other Member: The provision of Case Management services to one Member will not entitle the Member or any other Member to Case Management services or be construed as a waiver of Our right to administer and enforce this Benefit Plan in accordance with its express terms.
- D. Unless expressly agreed upon by the Us, all terms and conditions of this Benefit Plan, including but not limited to maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Member is receiving Case Management services.
- E. The Member's Case Management services will be terminated upon any of the following occurrences:
 - 1. We determine in Our sole discretion, that a Member is no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.
 - 2. The short and long-term goals established in the Case Management plan have been achieved, or the Member elects not to participate in the Case Management plan.
 - 3. The Member exhausts his maximum Benefits under this Benefit Plan; the Member ceases to be eligible to receive Benefits or ceases to be covered under the terms of this Benefit Plan; this Benefit Plan is amended or terminated so as to eliminate the Member's eligibility to receive Benefits and/or coverage under the terms of this Benefit Plan; or any other event that results in the Member's ineligibility to receive Benefits and/or loss of coverage under this Benefit Plan.

ARTICLE XVIII. ALTERNATIVE BENEFITS

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

a waiver of the Company's right to administer and enforce this Benefit Plan in accordance with its express terms.

- C. Unless expressly agreed upon by the Company, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Member is receiving Alternative Benefits.
- D. Alternative Benefits provided under the Article are provided in lieu of the Benefits to which the Member is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Benefit Plan.
- E. The Member's Alternative Benefits will be terminated upon any of the following occurrences:
 - 1. We determine, in Our sole discretion, that the Member is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.
 - 2. The Member receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by Us.
 - 3. The Member exhausts his maximum Benefits under this Benefit Plan; the Member ceases to be eligible to receive Benefits or ceases to be covered under the terms of this Benefit Plan; this Benefit Plan is amended or terminated so as to eliminate the Member's eligibility to receive Benefits and/or coverage under the terms of this Benefit Plan; or any other event that results in the Member's ineligibility to receive Benefits and/or loss of coverage under this Benefit Plan.

ARTICLE XXIX. LIMITATIONS AND EXCLUSIONS

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

- d. to the extent payment has been made or is available under any other contract issued by **HMO Louisiana, Inc.** or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law, and except for limited benefit policies;
 - e. paid or payable under Medicare Parts A or B when a Member has Medicare, except when Medicare Secondary Payer provisions apply;
 - f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures for such determinations which are on file with the Louisiana Department of Insurance;
 - g. rendered as a result of occupational disease or injury compensable under any Workers' Compensation Law subject to the provisions of L.R.S. 23:1205(C). This exclusion shall not apply to services rendered to a Member holding fifty percent (50%) or more ownership in the Group (or an employer, if Group is an association of employers), if the Member has legally opted to be excluded from Workers' Compensation coverage for the Group and has furnished the Company with written verification of his or her ownership interest and exclusion from Workers' Compensation coverage at the time of enrollment or upon acquisition of the required ownership percentage;
 - h. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; or
 - i. ordered, prescribed, or rendered by a Provider who is related to a Member by blood, marriage or adoption, or who regularly resides in a Member's household.
5. Services in the following categories:
- a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
 - b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;
 - c. those occurring as a result of taking part in a riot or acts of civil disobedience;
 - d. those occurring as a result of a Member's commission or attempted commission of a felony; or
 - e. for treatment of any Member confined in a prison, jail, or other penal institution.
6. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**
- a. rhinoplasty;
 - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
 - c. gynecomastia;
 - d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Benefit Plan;
 - e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants;
 - f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;
 - g. diastasis recti;
 - h. biofeedback;

- i. lifestyle/habit changing clinics and/or programs;
 - j. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies.
 - k. industrial testing or self help programs (including, but not limited to, smoking cessation programs and supplies, and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations;
 - 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 (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered in the Schedule of Benefits;
 - b. eye exercises, visual training, or orthoptics;
 - c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;
 - d. hair pieces, wigs, hair growth, and/or hair implants;
 - e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or
 - f. visual therapy.
8. Services, Surgery, supplies, treatment or expenses related to:
- a. any costs of donating an organ or tissue for transplant when a Member is a donor except as provided in this Benefit Plan;
 - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high dose chemotherapy to support transplant procedures;
 - c. the transplant of any non-human organ or tissue; or
 - d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.
9. Regardless of Medical Necessity, Benefits are not available for any of the following, except as specifically provided for in this Benefit Plan:
- a. weight reduction programs;
 - b. removal of excess fat or skin, regardless of Medical Necessity, or services at a health spa or similar facility; or
 - c. obesity or morbid obesity, regardless of Medical Necessity.
10. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.
11. Services or supplies for the treatment of eating disorders, unless otherwise required by law.
12. No Benefits will be provided under this Benefit Plan for any charges incurred for any Pre-Existing Condition, subject

to the following:

- a. except for Mental Disorders, a Pre-Existing Condition exclusion is limited to a one hundred eighty (180) day period (eighteen (18) months for Late Enrollees), less the period of Creditable Coverage.
 - b. a Pre-Existing Condition exclusion is limited to sixty (60) days for Mental Disorders, less the period of Creditable Coverage.
 - c. a Pre-Existing Condition exclusion cannot be applied to pregnancy.
 - d. a Pre-Existing Condition exclusion cannot be applied to a newborn, an adopted child under the age of eighteen (18) or a child placed for adoption under the age of eighteen (18), if they are covered under Creditable Coverage within thirty (30) days of birth, adoption, or placement for adoption without a Significant Break in Coverage.
 - e. a diagnosis is not necessary for a condition to be a Pre-Existing Condition.
13. Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits:
- a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Meridia®, Xenical®), or medications used to enhance athletic performance;
 - b. any medication not proven effective in general medical practice;
 - c. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug;
 - d. fertility drugs;
 - e. minerals and vitamins, except for vitamins requiring a prescription for dispensation;
 - f. nutritional or dietary supplements, or herbal supplements and treatments;
 - g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available;
 - h. contraceptive drugs;
 - i. contraceptive devices that do not result in permanent sterilization;
 - j. 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;
 - k. any drugs used for smoking cessation except Zyban;
 - l. 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;
 - m. drugs for non-Covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®);

- n. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;
 - o. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage;
 - p. Prescription Drugs related to a non-Covered Service;
 - q. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®);
 - r. 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;
 - s. growth hormone therapy, except for chronic renal insufficiency, AIDS wasting, and Turners Syndrome, unless an endocrinologist confirms growth hormone deficiency with abnormal provocative stimulation testing;
 - t. Prescription Drugs for and/or treatment of idiopathic short stature; or
 - u. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Member misrepresentation to that prescriber. Limitation may include, but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy.
14. Coverage is not available for self-administered Prescription Drugs (e.g., oral or self-injectable drugs) when obtained from a Physician or other Provider who is not contracted with Our pharmacy benefit manager. Injectable drugs that can be self-administered are not covered when obtained from an infusion therapy provider, unless prescribed in conjunction with intravenous infusions provided by the infusion therapy provider.
 15. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Member's Coinsurance and Our financial responsibility. We will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Member's Copayment, in which case, the Member must pay the Prescription Drug cost and sales tax.
 16. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Member's home or vehicle.
 17. Charges for telephone or e-mail Consultations between a Provider and a Member, failure to keep a scheduled visit, completion of a Claim form, or to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.
 18. Palliative or cosmetic foot care; care of flat foot conditions; supportive devices for the foot, except when used in the treatment of diabetic foot disease; care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints related to the feet.
 19. Any abortion other than to save the life of the mother.
 20. 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.
 21. 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.
 22. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.

23. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.
24. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.
25. Services, supplies or treatment for cosmetic purposes, Cosmetic Surgery and any complications of Cosmetic Surgery, unless required for a Congenital Anomaly.
26. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits.
27. Diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition.
28. 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.
29. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.
30. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Benefit Plan for diabetes; diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.
31. 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.
32. Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.
33. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.
34. Hospital charges for a well newborn.
35. Services or supplies for the treatment of alcohol and/or drug abuse, unless shown as Covered Services in the Schedule of Benefits.
36. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
37. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan.
38. Surgical and medical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP).
39. Paternity tests and tests performed for legal purposes.
40. Genetic testing, unless the results are specifically required for a medical treatment decision on the Member.
41. Reversal of a voluntary sterilization procedure.
42. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us; all defibrillators other than implantable defibrillators Authorized by Us.
43. Sleep studies, unless obtained in a facility that is accredited by the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO) or the American Academy of Sleep Medicine (AASM). If a sleep study is obtained from a facility that is not accredited by one of these bodies, then neither the sleep study nor any professional claims associated with the sleep study are eligible for coverage.

44. Applied Behavior Analysis (ABA) that the Company has determined is not Medically Necessary. ABA rendered to Members age seventeen (17) and older. ABA rendered by a Provider that has not been certified as a behavior analyst by the Behavior Analyst Certification Board or rendered by a Provider that has not provided, to the satisfaction of Company, documented evidence of equivalent education, professional training, and supervised experience in ABA.

ARTICLE XX. CONTINUATION OF INSURANCE UPON DEATH OF THE SUBSCRIBER

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

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

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

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

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

ARTICLE XXI. CONTINUATION OF INSURANCE

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

A Subscriber whose coverage under this Benefit Plan ends because of termination of active employment or termination of membership in the eligible class or classes under this Benefit Plan may be entitled to continue the coverage under this Benefit Plan for himself/herself and his or her eligible Dependents who were covered on the date the coverage ended until the earliest of the following dates:

- Twelve calendar months from the date the Subscriber's coverage ended; or
- The date ending the period for which the Subscriber last paid any required premium contribution; or
- The date the Subscriber becomes eligible for similar group coverage; or
- The date this Benefit Plan ends.

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

- The Subscriber was not continuously covered under this Benefit Plan or another group Benefit Plan that this Benefit Plan has replaced, for three (3) consecutive months immediately preceding the date his or her coverage ended; or
- The Subscriber becomes eligible for other group coverage or government sponsored health plan such as Medicare and Medicaid within thirty-one (31) days after coverage under this Benefit Plan ends; or
- The Subscriber's coverage under this Benefit Plan terminated due to fraud or failure to pay his or her required contribution to premium; or
- The Subscriber is eligible for continuation of coverage under COBRA.

The Subscriber must notify the Group in writing of his or her election to continue this Group health coverage and must pay any required contribution to the Group no later than the date on which coverage under this Benefit Plan would otherwise end. A form providing notification of the Subscriber's election to continue his or her coverage is available from the Group.

ARTICLE XXII. COBRA CONTINUATION OF COVERAGE

Benefits will be paid if required by the Uniformed Services Employment and Reemployment Rights Act of 1994 as amended (USERRA).

The following provisions are applicable only if the employer is subject to the Consolidated Omnibus Reconciliation Act of 1985 and any amendments thereto. See the Group Human Resources Manager for details about COBRA.

MEMBERS MUST FOLLOW ALL NOTICE AND TIME PERIOD REQUIREMENTS OR LOSE THE RIGHT TO COBRA CONTINUATION COVERAGE.

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

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and any amendments thereto, certain covered Subscribers and Dependents who would otherwise lose coverage as a result of a qualifying event, will have the option of continuation of that coverage without evidence of insurability.

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

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

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

The qualified beneficiary must notify the Group (in writing if required by the Group) if the qualifying event is a divorce or legal separation or if a Dependent child loses eligibility for coverage, within sixty (60) days of the occurrence of the qualifying event.

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

A Member may be required to pay the applicable premium for continued coverage plus an amount to cover administrative expenses. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Member otherwise would lose coverage under the group health plan (the termination date); and
- ends sixty (60) days after the termination date or sixty (60) days after the Member is notified of their right to continue coverage.

If continuation of coverage is elected, the qualified beneficiary then has forty-five (45) days within which to make the first premium payment.

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

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

Note: The eighteen (18) months may be extended to twenty-nine (29) months if a qualified beneficiary who is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) before the first day of COBRA coverage or becomes disabled during the first sixty (60) days of COBRA coverage. This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. The qualified beneficiary must notify the Group of the disability determination before the end of the initial eighteen (18) month COBRA period and within sixty (60) days from:

- the date of the disability; or
- the date of the qualifying event;

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

- thirty-six (36) months after the date of termination due to any other qualifying event; or
- the date the employer ceases to maintain any group health plan; or
- the date coverage ceases because of non-payment of required premiums; or
- the date the Subscriber or Dependent first becomes covered after the date of the COBRA election under another group health plan and benefits under that plan are not excluded or limited with respect to a Pre-Existing Condition; or
- the date the Subscriber or Dependent becomes entitled to Medicare after the date he or she elects COBRA coverage.

Note: Special rules may apply for the duration of coverage under COBRA for certain retirees and their Dependents who lose coverage as a result of an employer's bankruptcy, which is a "qualifying event." In this event, certain retirees and certain Dependents of retirees who are deceased at the time of the qualifying event, may elect lifetime COBRA coverage as of the date of the bankruptcy proceeding. Otherwise, eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA

coverage under these circumstances will terminate early for a number of reasons including but not limited to: the employer ceases to provide any group health plan to any employees or the qualified beneficiaries fail to pay the required premiums or become covered under another employer's group health plan that does not exclude or limit benefits for a qualified beneficiary's Pre-Existing Conditions.

Second Qualifying Event:

If a Subscriber and Dependent(s) experience another qualifying event while receiving eighteen (18) months of COBRA continuation of coverage, the Dependents who were qualified beneficiaries at the time of the first qualifying event, may qualify for up to eighteen (18) additional months of COBRA continuation of coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Group within sixty (60) days of the second qualifying event. This extension may be available to Dependents receiving continuation of coverage if:

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

The second qualifying event is applicable only if the event would have caused the Dependent to lose coverage under the plan had the first qualifying event not occurred.

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

ARTICLE XXIII.

COORDINATION OF BENEFITS

A. Applicability

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

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

1. "Plan" means any group, group-type, or blanket health plan which provides benefits for services, supplies, or equipment for Hospital, surgical, medical, or dental care or treatment, including, but not limited to, coverage under:

- a. insurance policies, non-profit health service plans, health maintenance organizations, Subscriber contracts, self-insured plans, pre-payment plans, automobile or homeowners medical payments plans, and Hospital indemnity plans with respect to benefits under these plans in excess of three hundred dollars (\$300) per day;
- b. government programs, including compulsory no-fault automobile insurance, unless an applicable law forbids coordinating benefits with this type of program;
- c. labor-management trustee plans, union welfare plans, employer organization plans, employee benefit organization plans, and professional association plans;
- d. any other employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended;
- e. Medicare as permitted by federal law;
- f. group-type plans or policies which can be obtained only because of employment with or membership in a particular organization, corporation, or other business entity.

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

Each plan or other arrangement for coverage is a separate plan. If an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is a separate plan.

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

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

When This Plan is a Secondary Plan, its Benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two (2) plans covering the person, This Plan may be a Primary Plan as to one (1) or more other plans, and may be a Secondary Plan as to a different plan or plans.

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

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

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

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

C. Order of Benefit Determination Rules

- 1. When there is a basis for a Claim under This Plan and another plan, This Plan is a Secondary Plan which has its Benefits determined after those of the other plan, unless:

- a. the other plan has rules coordinating its benefits with those of This Plan; and,
 - b. both those rules and This Plan's rules, in paragraph 2. below, require that This Plan's Benefits be determined before those of the other plan.
2. This Plan determines its order of Benefits using the first of the following rules which applies:

- a. Non-Dependent/Dependent: The benefits of the plan which covers the person as an employee, Member or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

- (1) Secondary to the plan covering the person as a Dependent, and

- (2) Primary to the plan covering the person as other than a Dependent (e.g., a retired employee), then the benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.

- b. Dependent Child/Parents Not Separated or Divorced: Except as stated in paragraph 2(c) below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents":

- (1) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the calendar year; but

- (2) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

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

- (1) first, the plan of the parent with custody of the child;

- (2) then, the plan of the spouse of the parent with custody of the child; and

- (3) finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

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

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

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

- (1) First, the benefits of a plan covering the person as an employee, Member or Subscriber (or as that person's Dependent);

(2) Second, the benefits under the continuation coverage.

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

- g. Longer/Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, Member or Subscriber longer are determined before those of the plan which covered that person for the shorter time.

D. Effects on the Benefits of this Plan

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

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

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

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

E. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. 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 We made more than it should have paid under this COB section, We may recover the excess. We may get such recovery or payment from one or more of:

1. The persons We have paid or for whom We have 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 XXIV. GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS

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

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

A. This Benefit Plan

1. This Benefit Plan, including the Application for Group Coverage, and any Application Benefit Change Forms, expressing the entire money and other consideration therefore, Schedule of Benefits, and any attached amendments or endorsements, constitutes the entire Benefit Plan between the parties.
2. Except as specifically provided herein, this Benefit Plan will not make Us liable or responsible for any duty or obligation that is imposed on the employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended, the Group will be the administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those that We specifically undertake herein. To the extent that this Benefit Plan is subject to COBRA, the Group will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Company harmless in the event the Company incurs any liability as a result of the Group’s failure to do so.
3. We will not be liable for, or on account of, any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with the Member’s care or treatment.
4. The Company has full discretionary authority to determine eligibility for Benefits and/or to construe the terms of this Benefit Plan.
5. We shall have the right to enter into any contractual agreements with subcontractors, health care providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by Us under this Benefit Plan may be performed by Us or any of Our subsidiaries, affiliates, subcontractors, or designees.

B. Benefit Plan Changes

Subject to all applicable laws, We reserve the right to modify the terms of this Benefit Plan upon not less than thirty (30) days notice to the Group. No change or waiver of any Benefit Plan provision will be effective until approved by Our chief executive officer.

C. Identification Cards and Benefit Plan

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

D. Benefits to Which Members Are Entitled

1. Our liability is limited to the Benefits specified in this Benefit Plan.

2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.
3. We, in Our sole discretion, may set a minimum dollar amount for claims to be reviewed for possible Pre-Existing Conditions.

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

1. The Group is solely responsible for furnishing the information that We require for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations, and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate Us to provide Benefits under this Benefit Plan.
2. All notification of membership or coverage changes must be on forms that We approve and include all information required by US to effect changes.
3. The Group must notify Our Membership & Billing Department of a Member's termination of coverage by completing a cancellation form (or such other form of notification acceptable to Us) and submitting it to Our offices no later than thirty (30) days after the Member's termination from employment or eligibility for coverage ends. The Group will also submit to Our Membership & Billing Department evidence of a Member's election of any applicable COBRA or state continuation of coverage following such termination within three (3) business days of the Group's receipt of signed continuation forms from the Member. Company is under no obligation to refund any premium paid by Group or any Member, if payment was made to Company due to Group's failure to timely notify Company of a Member's termination of coverage.
4. The Group warrants the accuracy of the information it transmits to Us and understands that We will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as requested by US.
5. The Group further agrees to indemnify Us for all expenses We may incur as a result of the Group's failure to transmit correct information in the time period that We require. Indemnification includes but is not limited to Claims payments made on behalf of individuals that are not eligible for Benefits. Alternatively, the Company may, at its sole option, hold the Group responsible for all premium payments for Members who are not timely cancelled from coverage due to the Group's failure to timely notify the Company of terminations or changes in eligibility.

F. Termination of a Member's Coverage

1. A Member's coverage may be terminated for fraud at any time. A Member's coverage may be terminated within three (3) years of the Member's Effective Date, if material misrepresentation was made in connection with enrollment for coverage.
2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, a Member's coverage terminates as provided below:
 - a. The Subscriber's coverage and that of all his Dependents automatically, and without notice, terminates at the end of the billing cycle in which the Subscriber ceases to be eligible.
 - b. The coverage of the Subscriber's spouse will terminate automatically and without notice at the end of the billing cycle for which premiums have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.
 - c. The coverage of a Dependent will terminate automatically, and without notice, at the end of the billing cycle in which the Dependent ceases to be an eligible Dependent, if premiums have been paid through that period.
 - d. Upon the death of a Subscriber, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if premiums have been paid through that period. However, a surviving spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.

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

G. Filing of Claims

1. A Claim is a written or electronic proof of charges for Covered Services that a Member has incurred during the time period he was insured under this Benefit Plan. We will not be liable under this Benefit Plan unless a Claim, in a form acceptable to Us, is filed with Us within ninety (90) days from the date services are rendered. If it is not reasonably possible to file the Claim within this time, We will allow more time. The Claim must then be filed as soon as possible, but not more than fifteen (15) months after the Claim is incurred. Benefits will be denied for Claims filed any later than fifteen (15) months from the date of service. The Claim must contain the data necessary for Us to determine Benefits. A Claim will be considered incurred on the date services or supplies are provided. Benefit Plan 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.
2. When filing Claims for Prescription Drugs, the Member must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to Us, must be completed and signed by the dispensing pharmacist. The Claim form should then be sent to Us.

G. Legal Action

No lawsuit may be filed:

1. any earlier than the first sixty (60) days after notice of Claim has been given; or
2. any later than fifteen (15) months after the date services are rendered.

I. Release of Information

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

J. Assignment

1. The Member's rights and Benefits payable under this Benefit Plan are personal to the Member and may not be

assigned in whole or in part by the Member. We will recognize assignments of Benefits to Hospitals if this Benefit Plan is subject to La. R.S. 40:2010. If this Benefit Plan is not subject to La. R.S. 40:2010, We will not recognize assignments or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the health plan or Us liable to any third party to whom the Member may be liable for the cost of medical care, treatment, or services.

2. We reserve the right to pay HMOLA Network Providers, and/or Providers in the Blue Cross and Blue Shield of Louisiana Participating Provider Network directly instead of paying the Member.

K. Member/Provider Relationship

1. The choice of a Provider is solely the Member's.
2. We 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. HMO Louisiana, Inc. does not render Covered Services but only makes payment for Covered Services that the Member receives. We are not liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider or in any Network Provider's facilities. We have no responsibility for a Provider's failure or refusal to render Covered Services to the Member.
3. The use or non-use of an adjective such as Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

L. Applicable Law

This Benefit Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law.

If any provision of this Benefit Plan is in conflict with any applicable statutes of the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute.

M. This Benefit Plan and Medicare

1. For employers having twenty (20) or more active employees, federal law and regulations require that each active employee age sixty-five (65) or older, and each active employee's spouse age sixty-five (65) or older, may elect to have coverage under this Benefit Plan or under Medicare.
 - a. Where such employee or such spouse elects coverage under this Benefit Plan, this Benefit Plan will be the primary payor of Benefits with the Medicare program the secondary payor.
 - b. This Benefit Plan will not provide Benefits to supplement Medicare payments for 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, this Group Benefit Plan is the primary payor and Medicare is the secondary payor.
3. For persons under age sixty-five (65) who are covered under this Benefit Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Benefit Plan the secondary payor except that during the first thirty (30) month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, this Benefit Plan will be the primary payor and Medicare the secondary payor.
4. When this Benefit Plan is the **primary** payor, it will provide regular Benefits for Covered Services.

When this Benefit Plan is the **secondary** payor, it will provide Benefits based on the lesser of: the Medicare approved amount or the Company's Allowable Charge. When an Allied Provider or Physician is not required by

Medicare to accept the Medicare approved amount as payment in full, We will base Benefits on the lesser of: the Medicare approved amount plus Medicare's limiting charge, if applicable, or the Company's Allowable Charge.

N. Notice

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

O. Job-Related Injury or Illness

The Group must report to the appropriate governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any legislation of any governmental unit. This Benefit Plan 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 L.R.S. 23:1205(C). In the event that We initially extend Benefits and a compensation carrier or employer makes any type of settlement with the Member, with any person entitled to receive settlement when the Member dies, or if his injury or illness is found to be compensable under law, the Group or the Member must reimburse Us for Benefits extended or direct the compensation carrier to make such reimbursement. We will be entitled to such reimbursement even if the settlement does not mention or excludes payment for health care expenses.

P. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, We will be subrogated and will succeed to the Member'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 Member who is its insured. The acceptance of such Benefits hereunder will constitute such subrogation. Our right to recover shall be subordinate to the Member's right to be "made whole." We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually incurred by the Member in pursuing recovery.
2. The Member will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured, to the extent of the Benefits provided or paid under this Benefit Plan. Our right to reimbursement shall be subordinate to the Member's right to be "made whole." We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by the Member in pursuing recovery.
3. The Member will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our rights, and will take no action prejudicing Our rights and interest under this Benefit Plan. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Benefit Plan.
4. The Member is required to notify Us of any Accidental Injury.

Q. Right of Recovery

Whenever any payment for Covered Services has been made by Us in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or whenever payment has been made in error by Us for non-Covered Services, We will have the right to recover such payment from the Member or, if applicable, the Provider. As an alternative, We reserve the right to deduct from any pending Claim for payment under this Benefit Plan any amounts that We are owed by the Member or the Provider.

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

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from Us to the extent the veteran would be eligible for Benefits for such care or services from Us 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 Us the reasonable cost of health care services incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that the retiree or Dependent would be eligible to receive reimbursement or indemnification from Us if the retiree or Dependent were to incur such cost on his or her or her own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

S. Liability of Plan Affiliates

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this agreement constitutes a Benefit Plan solely between Us and the Group, that We are 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 Us to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that We are not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Us and that no person, entity, or organization other than Us shall be held accountable or liable to the Group for any of Our obligations to the Group created under this agreement. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this agreement.

T. HIPAA Certificates of Creditable Coverage

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

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

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

We shall provide to certain Members who have Prescription Drug coverage under this Benefit Plan, without charge, a written certification that their Prescription Drug coverage under this Benefit Plan is either creditable or non-creditable. Coverage is deemed creditable if it is at least as good as the standard Medicare Part D prescription drug benefit. We will provide these certificates to covered Group Members who are eligible for Medicare Part D based upon enrollment data provided to Us by the Group. Group is responsible for providing a certificate to applicants prior to the Effective Date of coverage for new Medicare-eligible persons that join this Benefit Plan.

We will provide Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to Covered Members at the following times, or as designated by law:

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

5. Upon a Medicare beneficiary's request.

V. Out-of-Area Member Liability

A. BlueCard Program Member Liability – Member Provisions

When a Member obtains health care services through BlueCard outside the geographic area We serve, the amount the Member pays for Covered Services is calculated on the **lower** of:

- The billed charges for the Member's Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to Us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the Member's health care Provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with the Member's health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount the Member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Subscriber liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Subscriber liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, We would then calculate the Member's liability for any covered health care services in accordance with the applicable state statute in effect at the time the Member received his care.

B. Non-Participating Provider Member Liability

When You obtain health care services outside the geographic area We serve from a non-participating provider of the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") of that area, the amount You pay for Covered Services will generally be based on either the Host Blue's non-participating provider local payment amount/rate or the pricing arrangements required by applicable state law. Because the amount We generally pay for such non-participating providers' claims is based on the Host Blue's local payment amount/rate, You may be liable for the difference between the amount that the non-participating provider bills and the amount We will pay for the Covered Service as set forth in this contract.

ARTICLE XXV. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

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

The Member may be unhappy about decisions We make regarding covered services. We consider a Member's request to change Our coverage decision as an Appeal. Appeal procedures are outlined below, after the Complaint and Grievance procedure. In addition to the Appeals rights, a Member's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of Our coverage decision when they concern medical necessity determinations.

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

Complaint and Grievance Procedure

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

attitude and those of Our network Providers.

To register a Complaint:

Call Our Customer Service Department at 1-800-376-7741 or 1-225-293-0625. We will attempt to resolve a Member's Complaint at the time of their call.

To file a formal Grievance:

A Grievance is a written expression of dissatisfaction with Us or with Provider services.

If the Member does not feel their Complaint was adequately resolved or the Member wishes to file a formal Grievance, the Member must submit this in writing. Our Customer Service Department will assist the Member if necessary. Send written Grievances to:

HMO Louisiana, Inc.
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

A response will be mailed to the Member within 30 business days after We receive the Member's written Grievance. If the Member is not happy with Our handling of their Grievance, the Member has the right to elevate their Grievance to the second and final level. We must receive the Member's request for a second level Grievance no later than sixty (60) calendar days from the date We notified the Member of the answer to the first level Grievance. Grievances received after this date will not be considered. A separate panel reviews each level of Grievance.

Informal Reconsideration:

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

APPEAL PROCEDURES

Due to variations between federal and state laws, Appeals for ERISA members are handled differently from non-ERISA member appeals. Both ERISA and non-ERISA appeals processes are outlined below. The Member should contact their employer, Plan Administrator, Plan Sponsor, or Us at 1-800-376-7741 or 1-225-293-0625 if the Member is unsure which process applies to them.

The Member may submit appeals or communicate with Us regarding any appeal by writing to:

HMO Louisiana, Inc.
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

If the Member has questions or needs assistance putting the Appeal in writing, the Member may call Our Customer Service Department at 1-800-376-7741 or 1-225-293-0625. Providers will be notified of Appeal results only if the Provider filed the Appeal.

APPEAL PROCESS IF THE MEMBER IS NOT AN ERISA MEMBER

We will distinguish a Member's Appeal as either an administrative Appeal or a Medical Necessity Appeal. Depending on the amount at issue, Appeals for Investigational denials will follow either the administrative Appeal process, or the Medical Necessity Appeal process. The Appeals procedure has two internal levels, including review by a committee at the second

level. The Member is encouraged to provide Us with all available information to help Us completely evaluate the Member's Appeal. Medical Necessity Appeals also offer the Member the opportunity to appear in person or telephonically at a committee meeting as well as an opportunity for review by an independent external review organization.

The Member has the right to appoint an authorized representative to represent the Member in their Appeals. An authorized representative is a person to whom the Member has given written consent to represent the Member in an internal or external review of a denial. The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing and the Provider agrees and waives in writing, any right to payment from the Member other than any applicable Copayment or Coinsurance amount.

Investigational Appeals

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

An Investigational denial meets the "Investigational Appeals Threshold" when: (1) the allowable charge for the item or service exceeds five hundred dollars (\$500.00); (2) if the item or service is subject to FDA approval, it must be so approved; and, (3) if the item is not subject to FDA approval, use of the item or service must be supported by medical or scientific evidence.

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

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

First Level of Internal Appeal:

The Member, their authorized representative, or a Provider acting on the Member's behalf, must submit a request to Appeal the decision in writing. The Member has one hundred eighty (180) days following the receipt of an adverse benefit determination to request an Appeal. Requests submitted to Us after one hundred eighty (180) days of the denial will not be considered.

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

Second Level of Internal Appeal:

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

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

The Member or their authorized representative have the right to attend the review meeting for Medical Necessity Appeals, present the Member's position, and ask questions of the Committee members present, subject to the rules of procedure established by the Committee. If the Member is unable to appear before the Committee, but wish to participate, We will make arrangements for the Member to participate by means of available technology. For Medical Necessity Appeals, a Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review must agree with any adverse decision made by the Committee. The Committee will mail its decision regarding either the Member's Medical Necessity Appeal to the Member within five (5) working days after the meeting. Medical Necessity Appeals only can be elevated to the third and final review, review by an independent external review organization.

Independent External Review

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

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

Expedited Internal Appeal

We provide an Expedited Internal Appeal process for review of an adverse determination involving a situation where the time frame of the standard Appeal would seriously jeopardize a Member's life, health or ability to regain maximum function. In these cases, We will make a decision no later than seventy-two (72) hours after the review commences.

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

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

HMO Louisiana, Inc.
Expedited Appeal - Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045
1-800-376-7741 or 1-225-293-0625

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

Expedited External Review

An Expedited External Review is a request for immediate review, by an Independent Review Organization (IRO), of an adverse initial determination not to Authorize continued services for Members currently in the emergency room, under observation in a facility or receiving Inpatient care. The Member's health care Provider must request the Expedited External Review. Expedited External Reviews are not provided for review of services previously rendered. An Expedited External Review of an adverse decision is available if pursuing the standard Appeal procedure could seriously jeopardize the Member's life, health or ability to regain maximum function.

Within sixty (60) days of the denial, the Provider should contact Us to request this level of review. We will forward all pertinent information to the IRO so the review is completed no later than seventy-two (72) hours after the review

commences. Any decision rendered by the IRO is binding on Us and the Member for purposes of determining coverage under a health benefit plan that requires a determination of Medical Necessity. This Appeals process shall constitute the Member's sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary.

APPEAL PROCESS FOR ERISA MEMBERS

If the Member is an ERISA Member, We offer the Member two levels of appeal. The Member is required to complete the first level of appeal prior to instituting any civil action under ERISA section 502(a). The second level of appeal is voluntary. The two levels of review for administrative Appeals will be internal. The first level of review for Medical Necessity Appeals will be internal and an external Independent Review Organization (IRO) that is not affiliated with Us will handle the second voluntary level of review.

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

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

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

Investigational Appeals

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

An Investigational denial meets the "Investigational Appeals Threshold" when: (1) the allowable charge for the item or service exceeds five hundred dollars (\$500.00); (2) if the item or service is subject to FDA approval, it must be so approved; and, (3) if the item is not subject to FDA approval, use of the item or service must be supported by medical or scientific evidence.

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

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

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

The Member, their authorized representative, or Provider acting on the Member's behalf must submit a request to Appeal the decision in writing within 180 days following the receipt of an adverse benefit determination. Requests submitted after 180 days will not be considered.

In the case of a claim involving urgent care as defined below, we will expedite the review process. The Member may request an expedited review orally or in writing. All necessary information may be transmitted between the parties by telephone, facsimile, or other available similarly expeditious means.

We will review the Member's appeal promptly. The Member will receive notice of our review decision for:

1. Urgent care claims as soon as reasonably possible taking into account medical exigencies, but not later than 72 hours

after We receive the Member's request for an appeal of an adverse benefit determination. ("Urgent care claim" means any claim with respect to which the application of the time periods for making non-urgent care determinations (a) could, in the opinion of a prudent person with an average knowledge of health or medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.)

2. Pre-service claims within a reasonable period of time appropriate to the medical circumstances but not later than 30 days after We receive the Member's request for appeal of an adverse benefit determination. ("Pre-service claim" means any claim for a benefit under the plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval or Authorization of the benefit in advance of obtaining care or treatment.)
3. Post-service claims within a reasonable period of time but not later than thirty (30) days after We receive the Member's request for appeal of an adverse benefit determination. ("Post-service claim" means any claim for a benefit under the plan that is not an Urgent Care Claim or a Pre-service Claim as defined.)

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

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

Second Level Administrative Appeal (Voluntary):

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

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

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

Second Level Medical Necessity Appeal (Voluntary)

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

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

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

The Member may request this level of Appeal by sending a written request for an external review to Us within sixty (60) days of the Member's receipt of a level one denial. Requests submitted to Us after sixty (60) days of receipt of the denial will

not be considered. Members are entitled to only one IRO appeal. We will provide the IRO all necessary documents and information used in making the adverse determination to the IRO. The review will be completed within thirty (30) days from the IRO's receipt of the information from Us, unless the parties agree to a longer period. The IRO will notify the Member or their authorized representative and the Member's health care Provider of its decision.

ARTICLE XXVI.

ERISA RIGHTS

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

Receive Information About the Plan and Benefits

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

Continue Group Health Plan Coverage

- A plan participant may continue health care coverage for himself, his spouse, or his Dependents, if there is a loss of coverage under the plan as a result of a qualifying event. The participant or Dependents may, however, have to pay for such coverage. A participant may also review this document and the Summary Plan Description governing the plan on the rules pertaining to the participant's COBRA continuation of coverage rights.
- A plan participant may be entitled to a reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under his group health plan, if he has Creditable Coverage from another plan. The participant should be provided a HIPAA Certificate of Creditable Coverage, free of charge, from his group health plan or health insurance issuer when the participant loses coverage under the plan, when the participant becomes entitled to elect COBRA continuation of coverage, when the participant's COBRA continuation of coverage ceases, if the participant requests it before losing coverage, or if the participant requests it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, the participant may be subject to a Pre-Existing Condition exclusion for six (6) months (eighteen (18) months for late enrollees) after his enrollment date for coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Participant's Rights

- If a participant's claim for a plan benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps the participant can take to enforce the above rights. For instance, if the participant requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the participant may file suit in Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to one hundred ten dollars (\$110.00) a day until he

receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the participant has a claim for benefits, which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if he disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such participant may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if the participant is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person he has sued to pay these costs and fees. If the participant loses, the court may order him to pay these costs and fees, for example, if it determines that his claim is frivolous.

Assistance with Participant Questions

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

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

HMO Louisiana, Inc. is continuing to update its online access for Members. Members may now be able to perform many of the functions described below, without contacting Our Customer Service Unit. We invite Members to log on to www.bcbsla.com for access to these services.

All of the forms mentioned in this section can be obtained from the Member's employer's personnel office or from the home office of HMO Louisiana, Inc. The Change of Status Card has the health questionnaire on the reverse side. If the Member needs to submit documentation to Us, the Member may forward it to Our home office at:

HMO Louisiana, Inc.,
P. O. Box 98045 Baton Rouge
LA 70898-9045

or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809. If the Member has any questions about any of the information in this section, the Member may speak to their employer or call our Customer Service Department at the number shown on his ID card.

HOW TO OBTAIN CARE WHILE TRAVELING

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

- 1. In an Emergency, go directly to the nearest Hospital.**
- 2. Call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest BlueCard doctors and Hospitals.**
- 3. Use a designated BlueCard provider to receive the highest level of benefits.**
- 4. Present the Member's ID card to the doctor or Hospital, who will verify coverage and file claims for the Member.**
- 5. The Member must obtain any required Authorizations from HMO Louisiana, Inc.**

CHANGING FAMILY MEMBERS ON THE MEMBER'S POLICY

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

The Change of Status Card is the document that We must receive in order to enroll family members not listed on the Member's original application/enrollment form. The Schedule of Eligibility will tell the Member whether We require the

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

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

HOW TO FILE INSURANCE CLAIMS FOR BENEFITS

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

HMO Louisiana, Inc.,
P. O. Box 98024 Baton Rouge
LA 70898-9024

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

To assist in promptly handling the Member's claims, please be sure that:

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

IMPORTANT NOTE:

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

ADDITIONAL INFORMATION FOR FILING SPECIFIC CLAIMS

Admission to a Hospital or Allied Health Facility Claims

When the Member or an enrolled Member of the Member's family is being admitted to an HMOLA or Participating Provider, the Member should show their HMOLA ID Card to the admitting clerk. The Provider will file the claim with Us. Our payments will go directly to the HMOLA and Participating Provider. The Provider will then bill the Member directly for any remaining balance. The Member will receive an Explanation of Benefits after the claim has been processed.

Emergency Room or Outpatient Department Claims

The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility. However, in some instances involving Emergencies or Outpatient treatment the Provider may ask for payment directly from the Member. If

this occurs, the Member should obtain an itemized copy of the bill, be sure the claim form correctly notes the Benefit Plan number (ID #), the patient's date of birth, as well as the patient's relationship to the Subscriber. The Provider must mark the statement or claim form PAID. The Member should forward this statement to HMO Louisiana, Inc.

Claims for Mental Disorder, Alcohol and/or Drug Abuse

For help with filing a Claim for Mental Disorder, alcohol and/or drug abuse, the Member should refer to his or her Identification Card or call Our Customer Service Department.

Prescription Drug Claims

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

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

Other Medical Claims

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

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

IMPORTANT NOTE:

Itemized bills submitted with claim forms must include the following:

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

Claims for Nursing Services

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

Claims for Durable Medical Equipment (DME)

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.

IF THE MEMBER HAS A QUESTION ABOUT THEIR CLAIM

The Member's claim(s) will be processed in the home office in Baton Rouge

HMO Louisiana, Inc.,
5525 Reitz Avenue,
P.O. Box 98024

If the Member has a question about the payment of a claim, the Member can write Us at the above address or the Member may call Our Customer Service Department at the number shown on his ID Card or any of Our Local Service Offices.* If the Member calls for information about a claim, We can help the Member better if they have the information at hand--particularly the Benefit Plan number, patient's name and date of service.

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

*HMO Louisiana, Inc. has Local Service Offices located in Baton Rouge, New Orleans and Shreveport.

ARTICLE XXVIII. GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

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

A. Termination of Group

1. Subject to the following circumstances, We shall renew or continue coverage at the option of the Group. We may nonrenew or discontinue health insurance coverage under this Benefit Plan only if any one of the following occurs:
 - a. Fraud or intentional misrepresentations.
 - b. Failure by the Group to comply with a material plan provision including but not limited to provisions relating to eligibility, employer contributions, or group participation rules.
 - c. In the case of network plans, there is no longer any enrollee under the group health plan who lives, resides, or works in Our Service Area or in the area for which We are authorized to do business.
 - d. The Group's coverage is provided through a bona fide association and the employer's membership in the association ends.
 - e. The Company ceases to offer this product or coverage in the market.
 - f. Nonpayment of premiums.
2. If We terminate this coverage because of a, b, c, or d, we will give written notice to the Group at least sixty (60) days in advance, including the reason for termination. This notice shall be by certified mail and shall include the reason for termination. Notice of termination because of e will be made to the Group by regular mail ninety (90) days in advance of termination. Notice or termination for f will be given in accordance with the below provisions.
3. The Company reserves the right to terminate the Group when participation is less than two (2) employees. In cases where there is only one (1) employee (or owner, if covered) employed by the Group, termination will be effective on the Group's next anniversary date. In all other cases, a sixty (60) day written notification will be provided to the Group prior to termination.

B. Payment or Change in Premium:

1. Premiums are due and payable in advance, beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. The Group is considered delinquent if premiums are not paid as of the due date.
2. The Company offers a grace period of at least thirty (30) days from the date premium is due. If the premium is received during the grace period, coverage remains in effect pursuant to the provisions of the policy. If the premium is not received timely, We will mail a notice to the Group's address of record at least fifteen (15) days prior to terminating the policy for non-payment of premium. The policy may be automatically terminated without further notice to the Group if the Group does not make payment to Our home office within thirty (30) days of the due date. Any termination of this Benefit Plan will be effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the date of cancellation.

3. If a premium is not paid when due, We or an agent authorized by Us may agree to accept a late premium. We are not required to accept late premiums. The fact that We may have previously accepted a late premium does not mean we will accept late premiums in the future.
4. Premiums for this Benefit Plan may increase after the Group's first twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, We will give forty-five (45) days written notice to the Group at the last address shown in Our records regarding any change in rates. Such increase in premiums will become effective on the date specified in the notice and continued payment of premium will constitute acceptance of the change.

We reserve the right to increase the premiums more often than stated above due to the Group's addition of a newly covered person or entity not previously considered in the rate determination process at anytime during the life of the Benefit Plan. Additionally, We reserve the right to increase the premium amount because of: (1) any change in age or geographic location of any individual insured or policyholder; (2) a change in the extent or nature of the risk of the Group; or (3) any change in the policy Benefit level from that which was in force at the time of the last rate determination. Such increase of premium will become effective on the next billing date following the effective date of the change. Continued payment of premium will constitute acceptance of the change.

D. U.S. Economic Sanctions Laws Compliance

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

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

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

1. For purposes of this provision, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):
 - a. "Group Health Plan" as defined at 45 CFR Part 160, Sec. 160.103.
 - b. "Protected Health Information" (PHI) as defined at 45 CFR Part 164, Sec. 164.501.
 - c. "Summary Health Information" as defined at 45 CFR Part 164, Sec. 164.504(a).
2. Disclosing Information to the Group
 - a. Sharing Summary Health Information With the Group:

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

- b. Sharing PHI with the Group:

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

- (1) its plan documents include all of the requirements set forth in 45 CFR Part 164, Sec. 164.504(f)(2)(i), (ii) and (iii);
 - (2) it has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520 (B)(1)(iii)(C); and that such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other benefits or employee benefits plan of the Group.
- c. The Group hereby agrees to abide by the Company's acknowledgement and authorization policies with regards to the exchange of PHI in an electronic format. For example, if the Company provides data to the Group on a compact disc, the Company may require acknowledgement that the data was received by the Group and the name of the Group representative which received the data.

