Group Health Benefits

For The Employees of

Louisiana Sheriffs' Association

www.lsa.org

Administered by

BlueCross BlueShield of Louisiana

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NON-GRANDFATHERED GROUPCARE
HEALTH BENEFIT PLAN

NOTICE

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

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

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

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

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

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

LOUISIANA SHERIFFS' ASSOCIATION GROUP BENEFITS PROGRAM
COMPREHENSIVE MAJOR MEDICAL PLAN
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Please note:

Blue Cross and Blue Shield of Louisiana provide administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

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

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

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

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

A. Facts About This Preferred Provider Organization (PPO) Plan

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

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

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

B. Claims Administrator's Provider Network

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

The Preferred Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with the Claims Administrator to participate in the Blue Cross and Blue Shield of Louisiana Preferred Provider Network and render services to the Plan Participants. These Providers are called "Preferred network providers." Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's dental network.

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

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

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

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

C. Receiving Care Outside the Preferred Network

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

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

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

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

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

<u>In the United States</u>:

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

<u>Outside the United States</u>:

Plan Participants receive In-Network Benefits when covered Emergency and Non-Emergency Services are provided by a BlueCard Worldwide Provider across the world. If Plan Participants do not go to a BlueCard Worldwide Provider, Out-of-Network Benefits will apply. Covered Emergency Services are paid In-Network regardless of Provider.

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

2. Call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest PPO doctors and Hospitals (for care within the United States), or for information on BlueCard Worldwide doctors and Hospitals (for care outside the United States). Provider information is also available at **<u>www.bcbs.com</u>**.

3. Use a designated PPO Provider or BlueCard Worldwide Provider to receive the highest level of Benefits.

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

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

E. Authorizations

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

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

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

1. When a Plan Participant Uses Preferred Providers

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

2. When a Plan Participant Uses Participating Providers

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

3. When a Plan Participant Uses Non-Participating Providers

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

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

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

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

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

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

The Plan Participant receives Covered Services from:	Preferred network provider Hospital	Participating Provider Hospital	Non-participating Provider Hospital
Provider's Bill: Allowable Charge:	$12,000 $2,500	$12,000 $3,000	$12,000 $2,500
The Plan pays:	$2,000 $2,500 Allowable Charge x 80% Coinsurance = $2,000	$1,800 $3,000 Allowable Charge x 60% Coinsurance = $1,800	$1,500 $2,500 Allowable Charge x 60% Coinsurance = $1,500
Plan Participant pays:	$500 20% Coinsurance x $2,500 Allowable Charge = $500	$1,200 40% Coinsurance x $3,000 Allowable Charge = $1,200	$1,000 ($2,500 x 40% = $1000)
Is Plan Participant billed up to the Provider's billed charge?	NO	NO	YES - $9,500, for a total of:
TOTAL PLAN PARTICIPANT PAYS:	$500	$1,200	$10,500

H. When a Plan Participant Purchases Covered Prescription Drugs

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

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

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

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

J. Assignment

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

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

K. Plan Participant Incentives

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

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

L. Customer Service E-Mail Address

The Claims Administrator has consolidated its customer service e-mails into a single, easy-to-read address: help@bcbsla.com. Plan Participants who need to contact the Claims Administrator may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit **www.bcbsla.com** and click on "Contact Us."

ARTICLE II. DEFINITIONS

The terms set out below, wherever used in this Plan shall be construed as follows:

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

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

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

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

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

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

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

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

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

Appeal – A request from a Plan Participant or authorized representative to change a previous decision made by the Claims Administrator about Covered Services. Examples of issues that qualify as Appeals include denied Authorizations, Claims based on adverse determinations of Medical Necessity or Benefit determinations.

Applied Behavior Analysis (ABA) - The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Providers of ABA shall be certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board.

Authorization (Authorized) - A determination by Claims Administrator regarding an Admission, continued Hospital stay, or other health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the health care setting, or level of care and

effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Plan Participant's choice of Provider.

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

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

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

Benefit Period - means a calendar year beginning January 1 and ending December 31 of the same year. For new Plan Participants, the Benefit Period begins on the Effective Date and ends on December 31 of the same year.

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

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

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

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

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

Child – (see Dependent)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

condition in a patient who is not expected to improve or recover. The Claims Administrator determines which services are Custodial Care.

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

Deductible Amount

A. Benefit Period Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Plan Participant must pay within a Benefit Period before the Benefit Plan starts paying Benefits. Once the Family Deductible Amount is satisfied, this Plan starts paying Benefits for all Plan Participants of the family, regardless whether each has met his Benefit Period Deductible Amount. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits.

B. Family Deductible Amount - For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Benefit Period Deductible Amount. The Family Deductible Amount is met when the total dollar amount of charges for Covered Services, applied to satisfy individual Benefit Period Deductibles, meets or exceeds the Family Deductible Amount shown in the Schedule of Benefits. This Plan will then start paying Benefits for all Plan Participants within the family, regardless of whether each individual Plan Participant has met his individual Benefit Period Deductible. No Plan Participant may contribute more than his Benefit Period Deductible Amount to satisfy the aggregate Deductible amount required of a family. Family Deductibles may apply to other types of Deductibles described in this Plan. Only Benefit Period Deductible Amounts accrue to the Family Deductible Amount.

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

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

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

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

Dependent - means the legal spouse of an Employee/Retiree, and any Child who meets the following conditions:

A. Is a natural Child; or

B. Is a legally adopted Child (Note: an adopted Child who is awaiting final order of adoption is an eligible Dependent from the date the Child is placed in the Employee's home), foster child, stepchild, grandchild, or other child who both (I) lives with the Employee in a regular parent-child relationship and (ii) is dependent upon the Employee for principal financial support. Any natural or adopted Child of a previous marriage for which child support payments are being made is considered as an eligible Dependent.

C. Is less than twenty-six (26) years of age.

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

    a. This Benefit Plan provides a Special Enrollment Period for an employee or family Dependent(s) if either (1) are covered under Medicaid or State Children's Health Insurance Program ("CHIP"), and lose that coverage because of loss of eligibility; or (2) they become eligible for premium assistance under the CHIP program. To qualify, employee must request coverage in this Group health plan no later than sixty (60)

days after either the date of coverage termination under Medicaid or CHIP or the date employee or Dependent is determined to be eligible for such premium assistance. Request for special enrollment under this section must be received by a Blue Cross and Blue Shield of Louisiana office within the sixty (60) day period following loss of coverage or the date employee or Dependent is determined to be eligible for premium assistance. When special enrollment under this section is made timely and received by Company timely, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP or the date employee or Dependent is eligible for premium assistance.

b. Employee may disenroll a child Dependent from this coverage and enroll the child in CHIP coverage effective on the first day of any month for which the child is eligible for such CHIP coverage. Employee must promptly notify Company in writing of the child's disenrollment to avoid continued coverage under this Plan.

NOTE: No coverage will be made effective for a Child other than a natural Child until the Employee has submitted documentation which satisfies the Committee that both (a) a parent-child relationship exists, and (b) the Employee provides principal financial support for that Child.

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

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

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

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

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

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

Emergency – See "Emergency Medical Condition."

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

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

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

Employee - A person who is an active, regular Employee of the Sponsor, who works the required number of hours for coverage as designated by the Sponsor. Employed on a full-time (thirty (30) hours per week) permanent basis.

Employer - means each Parish Sheriffs' Department, when such groups have been accepted by the Plan for participation.

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

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

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

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

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

Group – Louisiana Sheriffs' Association Group Benefits Program or other legal entity of Louisiana Sheriffs' Association Group Benefits Program who is the Plan Administrator and sponsor of this Benefit Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

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

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

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

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

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

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

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

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

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

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

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

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

Inpatient Hospital Copayment Amount – The dollar amount, shown in the Schedule of Benefits, of charges for Covered Services rendered by a Hospital, which a Plan Participant must pay for each Admission. The Inpatient Hospital Copayment Amount does NOT accrue to the Benefit Period Deductible Amount and must be paid in addition to the Benefit Period Deductible Amount.

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

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

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

B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

    1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);

    2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or

    3. reference to federal regulations.

Medically Necessary (or Medical Necessity) - 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.

Medicare - means all applicable provisions of Title XVIII of the Social Security Act of 1965 as constituted and amended.

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychoses, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by La. R.S. 22:1043 (formerly 22:669) (schizophrenia or schizoaffective disorder; bipolar disorder; pervasive developmental disorder or autism; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; Asperger's disorder; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under seventeen (17) years of age; Rett's Disorder; and Tourette's Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic mental disorders, to be determined by the Plan. The definition of Mental Disorder 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 or another Blue Cross and Blue Shield Plan to participate as a member of the Preferred Care Provider Network or another PPO Network. This Provider may also be referred to as a Preferred Provider or In-Network Provider.

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

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

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

Non-Occupational Disease - means a disease that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from a disease, which does. However, if proof is furnished that the Plan Participant is covered under a Worker's Compensation law or similar law, but is not covered for a particular disease under such law, that disease will be considered "Non-Occupational" regardless of the cause.

Non-Occupational Injury - means an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an injury which does.

Occupational Accidental Injury - means an accidental bodily injury that arises out of (or in the course of) any work on behalf of the Sheriff's Department for pay.

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

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

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

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

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

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

Part-Time Employee - means a person employed on a part-time basis (less than thirty (30) hours per week) who may or may not receive pay for such work.

Physical Therapy **-** means the evaluation of physical status as related to functional abilities and treatment procedures as indicated by that evaluation. Such therapy is therapy provided by a registered physical therapist who is licensed to practice in the state where the service was rendered. Services provided must meet the following criteria: ordered by a Physician; requires the skills of a registered physical therapist; performed by or under direct supervision of a physical therapist; restorative potential exists; meets the standards for medical practice; reasonable and necessary for treatment of the illness, injury or post-operative condition.

Physician **-** means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed without limitation to practice medicine or perform surgery at the time and place the service is rendered. For services covered by this Plan only, doctors of dental surgery (D.D.S.), doctors of podiatric medicine (D.P.M.), doctors of chiropractic (D.C.), and doctors of optometry (O.D.), when acting within the scope of their licenses, are deemed to be Physicians. No practitioners other than those specified above shall be deemed to be Physicians for purposes of the Plan. Physician does not include interns, residents, fellows, or others enrolled in a residence training program.

Plan – Louisiana Sheriffs' Association Group Benefits Program's medical Benefits plan for certain Employees of Louisiana Sheriffs' Association Group Benefits Program and is described in this document.

Plan Administrator – The person or entity designated by the Plan Sponsor to administer this group Plan. For purposes of this Plan, the Plan Administrator is the Insurance Advisory Committee of the Louisiana Sheriffs' Association Group Benefits Program Group Benefits Plan.

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

Plan Sponsor – Louisiana Sheriffs' Association Group Benefits Program**,** who provides these Benefits on behalf of its eligible Employees, Retirees and their eligible Dependents.

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

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

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

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

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

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

The Prescription Drug Deductible Amount applies to Brand-Name Drugs only.

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

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

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

Prosthetic Appliance – 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.

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

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

A. Preferred network provider – A Provider who has entered into a contract with the Claims Administrator or another Blue Cross and Blue Shield plan to participate in a PPO network.

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

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

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

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

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

Retiree/Retired Employee - A former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the employer and elects to contribute to the Plan the contribution required from the Retired Employee.

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

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

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

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

D. Utilization review plans for all patients.

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

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

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

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

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

C. Unique patient compliance and safety monitoring requirements.

D. Unique requirements for handling, shipping and storage.

E. Restricted access or limited distribution.

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

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

Surgery

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

B. the correction of fractures and dislocations;

C. Pregnancy Care to include vaginal deliveries and caesarean sections;

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

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

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

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

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

Totally Disabled -- means:

A. For a covered Employee, the inability to engage in his or her occupation.

B. For a covered Dependent, the inability to engage in his or her customary duties and activities.

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

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

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

Waiting Period – See Eligibility Waiting Period.

Well Baby Care – Routine examinations of an infant under the age of twenty-four (24) months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the Routine Wellness Physical Exam Benefit.

ARTICLE III. SCHEDULE OF ELIGIBILITY

A. Active Full-Time Employees

Employee - means a person employed on a full-time (thirty (30) hours per week) permanent basis by the Employer.

B. Part-Time and Reserve/Auxiliary Deputies

Part-time and Reserve/Auxiliary Deputies who are commissioned and who work regularly on a part-time basis (less than thirty (30) hours per week) are eligible for specific coverage as defined herein based on individual Parish option. Dependents of such deputies are not eligible for coverage under the Plan.

C. Retirees

The following Retirees are eligible to participate in the Plan:

1. Retirees currently receiving benefits under the Association Pension Plan who have:

   a. Joined the Plan during the ninety (90) days after their parish joined the Medical Plan;

   b. Exercised their option to continue coverage under the Medical Plan in the thirty (30) days from the date they ceased to be a full-time Employee.

   If such election is not made in the thirty (30) day option period or if the Retiree declines coverage, or drops coverage at any time after retirement, such person will not again be eligible to participate at any time in the future.

2. Employees who have qualified for retirement by years of service, but not by age (Deferred Retirees), who have:

   a. Joined the Plan during the ninety (90) days after their parish joined the Medical Plan; or

   b. Exercised their option to continue coverage under the Plan in the thirty (30) days from the date that they ceased to be an active full-time Employee.

   If such election is not made in the thirty (30) day option period or if the Deferred Retiree declines or drops coverage from the date he or she ceased to be eligible as an active full-time Employee, such person will not again be eligible until the date he or she becomes eligible to draw retirement benefits. On that date, he or she may become eligible to participate in the Medical Plan, but will be required to show evidence of good health before acceptance, and application must be made within thirty (30) days of the date the Retiree becomes eligible.

3. Former Employees who did not qualify for retirement, but had accumulated twelve (12) or more years of full-time service, who have exercised their option to continue coverage under the Plan within thirty (30) days from the date they ceased to be an active full-time Employee.

4. Employees who have qualified for retirement by years, but not by age, who have exercised their right to join the program during the ninety (90) day open enrollment or have exercised their option to continue under the Plan, and their Dependents as defined in ARTICLE II, DEFINITIONS, are eligible to participate in the Plan.

   Dependents covered by the Retiree the day prior to retirement, may be included by Retirees only on the Retirees' initial effective date of coverage. A Retiree may not add Dependent coverage at a date later than his or her initial date of coverage unless adding a new spouse within 30 days of marriage, or adding a Dependent child within 30 days of eligibility.

5. To comply with House Bill 253, Act 314 of 1999 which provides "the premium costs of group hospital, surgical, medical expenses, and dental insurance and the first ten thousand dollars of life insurance

contracted under the provisions of this Section shall be paid in full from the sheriff's general fund for all sheriffs and deputy sheriffs retired with a minimum of fifteen years of service and are fifty-five years of age," effective April 1, 2000 the Plan will open participation to Retirees of Sheriff Offices participating in the Louisiana Sheriffs' Association Group Benefits Program's Medical, Dental and Life Plan who were not eligible for coverage upon retirement. Participation is further limited to Retirees of the parishes that are enumerated in Act 314 of 1999. This open enrollment period is from April 1, 2000 through April 30, 2000 for an effective date of April 1, 2000. Coverage into the Plan is for the Retiree only and does not include dependents.

D. Employee - Initial Eligibility Date

1. Each Employee whose employment commenced on or before the effective date of this Plan shall become eligible for coverage on the effective date of this Plan.

2. Each Employee whose employment commences after the effective date of this Plan shall become eligible for coverage on his or her date of employment, provided application for coverage has been made by that date. If application for coverage is made within one (1) month after the date of employment, coverage will become effective on the date application is made.

E. Dependent - Initial Eligibility Date

1. Each eligible Dependent of an Employee or Retiree whose employment commenced on or before the effective date of this Plan shall become eligible for coverage on the effective date of this Plan.

2. Each eligible Dependent of an Employee whose employment commences after the effective date of this Plan shall become eligible for coverage on the Employee's date of employment, or, if later, the date the Employee makes application for Dependent coverage, provided such application is made within one (1) month after the Dependent's initial eligibility date.

3. A Dependent Child who is ordered by the court to be covered under the Plan will be eligible for coverage when required by such court or administrative order, to comply with the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). This Plan will automatically be amended to include any change or interpretation to such law.

4. Adding Newborn Children to Coverage

   The Employee must notify the Third Party Administrator that the Employee is adding a child and the effective date of coverage. If the Third Party Administrator is notified within thirty (30) days of the date the child becomes eligible, the child's effective date will be the date the child became eligible. If the Third Party Administrator is not notified within thirty (30) days of the child becoming eligible for coverage, then evidence of good health requirements will apply. Once approved, the effective date will then be the first of the month following the date the change card was notarized.

F. In the event an Employer not participating in the Plan on the original effective date of the Plan begins participation subsequent to the effective date, any Participants in that Sponsor's group insurance plan on the day immediately preceding participation in this Plan shall be eligible for immediate coverage and:

1. There will be no Pre-Existing Conditions exclusion applicable to such participants;

2. Expenses applied toward the Deductible and Out-of-Pocket provisions of the prior plan shall be applied toward the Deductible and Out-of-Pocket provisions of this Plan, provided however,

3. Any benefits otherwise payable under this Plan shall be reduced by any benefits payable under the extended benefits provisions of the prior plan.

G. An Employee not enrolling self or Dependents as defined in ARTICLE II, DEFINITIONS, during their initial period of eligibility will be required to show proof of insurability. The effective date of coverage will be the first day of the month following the date the application or change card is notarized.

Acceptance or rejection of such application will be made by the Plan at its discretion based on the evidence of good health submitted. The type and form of required proof of good health will be determined by the Plan. The Employee will be required to pay the cost of obtaining such proof.

H. Actively At Work/Non-Confined Requirement

1. The effective date of coverage for an Employee not actively at work on his or her initial eligibility date will be deferred until the date he or she returns to active full-time employment.

2. The effective date of coverage for a Dependent who is confined, because of disease, illness, or injury, at home, in a nursing home, Hospital, or elsewhere on his or her initial eligibility date will be deferred until his or her confinement or disability ends.

   This provision will not apply to a newborn Child for whom coverage has previously been applied for or who is the Dependent of an Employee already enrolled for Child or family coverage.

I. Dependents, as defined in ARTICLE II, DEFINITIONS, of an Employee who are covered at the time of the Employee's death are eligible as follows:

1. If the Employee is killed in the line of duty, eligibility continues as though the Employee had not died.

2. If an Employee with twelve (12) or more years of service dies, his or her Dependents will be eligible to continue coverage as though the Employee had not died.

3. If an Employee with five (5) years, but less than twelve (12) years of service dies other than in the line of duty, his or her Dependents will be eligible to continue participation in the Plan for two (2) years after the Employee's death.

4. If an Employee with less than five (5) years of service dies other than in the line of duty, his or her Dependents will be eligible to continue participation in the Plan for one (1) year after the Employee's death.

Dependents have thirty (30) days after the death of an Employee or Retiree to make a decision as to continuation of coverage. After thirty (30) days, Dependents will be dropped from the Plan and will not again be entitled to coverage.

J. If an Employee's employment terminates for reasons other than (a) retirement, or (b) termination of the Plan, the coverage terminates at midnight on the day employment terminates; however:

1. If the FULL – TIME Employee is granted a leave of absence because of the inability to work due to an on-the-job injury or a disease contracted while on the job, coverage may continue for up to twelve (12) months during such leave.

2. If the FULL – TIME Employee is granted a leave of absence for a work related leave of absence not defined in (1) above, (i.e., law enforcement education, sickness, off-the-job injury, work suspension, etc.), coverage may continue for up to six (6) months during such leave. Exception to the six (6) month extension is that an Employee who takes a leave of absence to run for Sheriff and is elected, can remain on the Plan under this extension for longer than six (6) months, until such time that he takes office or rejoins the department. At such time he or she will be considered an active Employee.

3. If the FULL – TIME Employee is granted a leave of absence for any reason not defined in (1) or (2) above, coverage may continue for up to ninety (90) days.

4. **NOTE:** The following shall apply to Employers who are subject to the Family Medical Leave Act (FMLA) of 1993.

   a. If the Employee qualifies under the Act to take a Family Medical Leave, the twelve (12) week entitlement under the FMLA will apply against any other continuation provision in this Plan.

   b. This Plan will comply with the continuation and reinstatement provision of the said Act.

The continuation of coverage as stated above is in addition to COBRA.

K. Special Transfer Provision

In the event an Employee's employment with a participating Employer terminates and the Employee begins employment with another participating Employer on the next regularly scheduled work day after termination of coverage with the original Employer, the coverage status for the Employee and any covered Dependents will be transferred in place; i.e., credit will be given for expenses previously applied toward satisfaction of current Deductible and Copayment. Any eligible Dependents who are age nineteen (19) or older who were not covered under the former participating Employer and who apply for coverage under the new participating Employer will be subject to the evidence of good health requirement of Section G of ARTICLE III, ELIGIBILITY AND TERMINATION.

ARTICLE IV. BENEFITS

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

A. Benefit Categories

1. Network Benefits (In-Network) – Benefits for medical care received from a Preferred Care Provider. When a Plan Participant receives care from a Network Provider, he will receive the highest level of Benefits on this Plan Network Benefits: Benefits for Covered Services received from a Network Provider (Providers contracted in the Preferred Care Network or another Blue Plan's PPO Network).

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

B. Deductibles and Coinsurance

1. Subject to the Deductible Amounts shown in the Schedule of Benefits, the maximum limitations hereinafter provided, and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in accordance with the Coinsurance percentage shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period. The following deductibles may apply to Benefits provided by this Plan. Deductibles do not accrue to the Out-of-Pocket Amount.

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

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

    c. Inpatient Hospital Copayment Amount: The dollar amount, if shown in the Schedule of Benefits, of Hospital charges that the Plan Participant must pay for each covered Admission. The Inpatient Hospital Copayment Amount does not accrue to the Benefit Period Deductible Amount and must be paid in addition to the Benefit Period Deductible Amount and the Family Deductible Amount.

d. Prescription Drug Deductible Amount: The dollar amount, if shown in the Schedule of Benefits, which each Plan Participant must pay within a Benefit Period prior to paying a Prescription Drug Copayment.

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

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

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

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

C. Out-of-Pocket Amount

After the Plan Participant has met the applicable Out-of-Pocket Amount, as shown in the Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Allowable Charges for Covered Services for all covered family members for the remainder of the Benefit Period.

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

   a. Deductible

   b. Coinsurance

   c. Copayment Amounts

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

   a. any charges in excess of the Allowable Charge;

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

   c. charges for non-Covered Services; and

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

D. Special Coinsurance Provision

For Plan Participants on the effective date of the Plan, who were covered under the Employer's group insurance plan in effect on the day immediately preceding the effective date of this Plan, expenses applied toward satisfaction of that plan's Out-of-Pocket amount will be allowed to apply this amount, in whole or in part, towards satisfying this Plan's Out-of-Pocket for the current benefit period. Proof, satisfactory to the Plan, of

expenses allowed toward the prior plan's Out-of-Pocket must be submitted to the Plan with the claim for such benefit.

E. Special Deductible Provision

For Plan Participants on the effective date of the Plan who were covered under the Employer's group insurance plan in effect on the day immediately preceding the effective date of the Plan, expenses applied toward satisfaction of that plan's deductible requirement will be allowed to apply this amount, in whole or in part, towards satisfying the Plan's Deductible for the current benefit period. Proof, satisfactory to the Plan, of expenses allowed toward the prior plan's deductible must be submitted to the Plan with the claim for such benefit.

F. Medical Benefits for Part-time and Reserve/Auxiliary Deputies

The medical coverage is limited to Covered Medical Expenses incurred as a result of an accidental injury occurring while on duty. Covered Medical Expenses for this Plan are the same as those described for full-time Employees and Retirees. There is a maximum benefit of fifty thousand dollars ($50,000.00) per accidental injury.

When an on-the-job injury occurs, the Employee must contact his particular Sheriff's Department and complete an accident report. Consideration cannot be given to such Employee's claim until the accident report is submitted to the Plan's Third Party Administrator.

ARTICLE V. HOSPITAL BENEFITS

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

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

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Plan Participant requiring an intensive level of care.
3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us.
4. In a Residential Treatment Center for Plan Participants with a Mental Disorder or substance abuse impairment.

B. Other Hospital Services (Inpatient and Outpatient)

1. Use of operating room, delivery room, treatment room and equipment
2. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital employee.
3. Medical and surgical supplies, casts, and splints.
4. Drugs and medicines including take-home Prescription Drugs.
5. Diagnostic Services rendered by a Hospital employee.

6. Physical Therapy provided by a Hospital employee

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

8. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.

C. Pre-Admission Testing Benefits

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

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

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

A. Surgical Services

1. Surgery

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

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

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

   a. Primary Procedure

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

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

   b. Secondary Procedure(s)

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

   c. Incidental Procedure

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

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

d. Unbundled Procedure(s)

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

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

e. Mutually Exclusive Procedure(s)

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

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

3. Assistant Surgeon

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

4. Anesthesia

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

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

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

5. Second Surgical Opinion

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

B. Inpatient Medical Services

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

1. Inpatient medical care visits.

2. Concurrent Care.

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

C. Outpatient Medical Services and Surgical Services

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

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

3. Diagnostic Services.

4. services of an Ambulatory Surgical Center.

5. services of an Urgent Care Center.

D. Expanded Medical and Surgical Benefits

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

ARTICLE VII. PRESCRIPTION DRUG BENEFIT

A. Coverage is available for Prescription Drugs. The Prescription Drugs must be dispensed on or after the Plan Participant's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge and only those Prescription Drugs that the Claims Administrator determines are Medically Necessary will be covered.

B. The Plan Participant can view the Claim Administrator's Blue Selections Rx Member Guide at **www.bcbsla.com** or request a copy by mail by calling the Claim Administrator's pharmacy benefit manager at the telephone number indicated on the Plan Participant's ID card.

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

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

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

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

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

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

   (b) common usage for episodic or intermittent treatment;

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

   (d) as determined by the Plan.

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

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

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

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

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

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

K. This Benefit Plan uses an open Prescription Drug formulary. A Prescription Drug formulary is a list of Prescription Drugs covered under the Plan. With an open formulary, new Prescription Drugs are automatically included to the list when drug manufacturers release these new drugs for sale. Placement of Prescription

Drugs on a drug tier may be based on a drug's quality, safety, clinical efficacy, available alternatives, and cost. The Claims Administrator reviews the Prescription Drug formulary at least once per year.

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

L. Prescription Drug Benefits

1. Prescription Drugs dispensed at retail or through the mail are subject to the applicable Prescription Drug Copayment amount or Coinsurance percentage shown in the Schedule of Benefits. The Plan Participant may be required to pay a different Copayment amount or Coinsurance percentage for the different drug tiers. The Copayment amount or Coinsurance percentage may also be different depending on whether the Plan Participant's Prescription Drugs are purchased at retail or through the mail. Certain Prescription Drugs may be subject to quantity limitations.

2. The Prescription Drug Deductible Amount is separate from the Benefit Period Deductible and must be satisfied prior to a Prescription Drug Copayment or Coinsurance.

    - The Prescription Drug Deductible applies to Brand-Name Drugs only.

3. The Plan Participant should present his or her ID card to the pharmacist when purchasing covered Prescription Drugs at a Participating Pharmacy. If the Plan Participant has not met his Deductible, the participating pharmacy may collect one hundred percent (100%) of the discounted costs of the drug at the point of sale. If the Plan Participant has met his Deductible, he will pay the Copayment or Coinsurance amount shown on the Schedule of Benefits. The participating pharmacy will electronically submit the Claim for the Plan Participant.

4. Prescription Drug Copayments or Coinsurance percentages are based on the following tier classifications shown in the Schedule of Benefits. Tier placement is based on the Claims Administrator's evaluation of a particular medication's clinical efficiency, safety, cost, and pharmacoeconomic factors.

    a. Tier 1 – A Prescription Drug that is a Generic or a low cost Brand-Name Drug.

    b. Tier 2 – A Prescription Drug that is a Brand-Name Drug.

    c. 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.

    d. Tier 4 – A Prescription Drug that is a Specialty Drug.

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

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

This Benefit Plan covers services recommended by the U.S. Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. The list of covered services changes from time to time. New Preventive or Wellness Care services usually become covered within one year from the date recommended. To

check the current list of recommended services, visit the U.S. Department of Health and Human Services' website at: **https://www.healthcare.gov/preventive-care-benefits/**.

A. Preventive or Wellness Care Benefits

1. The Deductible Amount does not apply to covered Preventive or Wellness Care received from a Preferred Provider, unless otherwise stated. Preventive or Wellness Care received from a Non-Network Provider is subject to the Deductible Amount shown in the Schedule of Benefits.

PREVENTIVE or WELLNESS CARE SERVICES	AGE / CRITERIA
EXAMINATIONS AND TESTING	
Colorectal Cancer Screening –	
• Fecal occult blood test: One (1) per Benefit Period. Additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	Ages 50 – 75
• Flexible sigmoidoscopy: One (1) every five (5) years. Additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	Ages 50 – 75
• Colonoscopy, including preparation supplies: One (1) every ten (10) years. Additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits.	Ages 50 – 75
• Other screening procedures as most recently recommended by the United States Preventive Services Task Force (USPSTF) and the American College of Gastroenterology, in consultation with the American Cancer Society. Services deemed Investigational are not covered.	Ages 50 – 75
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels). Higher tech services such as an MRI, MRA, CT scan, PET scan, nuclear cardiology, and endoscopy are not covered under this Preventive or Wellness Benefit but may be covered under standard Benefits.	All Ages
Well Baby Care	As recommended by physician for developmental milestones
IMMUNIZATIONS	
Immunizations recommended by Physician	All Ages
Seasonal Flu and H1N1 Immunizations	All Ages

SCREENINGS, COUNSELING AND SUPPLEMENTS	
Abdominal Aortic Aneurysm Screening: One (1) per Benefit Period	Men who have smoked: Ages 65 – 75
Alcohol Misuse Screening and Counseling	Adults: Ages 18 and older
Aspirin Counseling	Men: Ages 45 – 79 Women: Ages 55 – 79
Blood Pressure Screening	Ages 18 and older
Cholesterol Screening	Men: Ages 20 – 35 if at risk; or 35 and older Women: Ages 20 – 45 if at risk; or 45 and older
Depression Screening	Ages 12 – 18 and Adults
Diet Counseling	Adults with hyperlipidemia and other risk factors
Fall Prevention Intervention	Ages 65 and older
Generic Vitamin D (up to 800 IU)	Ages 65 and older
Hepatitis B Screening **NEW – Effective for plans issued or renewed on or after 1/1/2015**	Pregnant Women Non-pregnant, high risk adolescents and adults
Hepatitis C Screening	High risk adults or **adults born between 1945 and 1965**
HIV Screening and Counseling	Adolescents and Adults: Ages 15 – 65; younger or older if at increased risk Sexually active women
Lung Cancer Screening **NEW – Effective for plans issued or renewed on or after 1/1/2015**	Adults: Ages 55 – 80 (per guidelines for smoking history)
Obesity Screening and Counseling	Adults with a body mass index higher than 30 kg/m^2
Sexually Transmitted Infection Counseling	Sexually active adolescents 11 – 21 and adults at increased risk
Skin Cancer Screening	Ages 10 – 24

Syphilis Screening	Adults at increased risk Pregnant women
Tobacco Use Screening and Counseling	Adults; school-aged children and adolescents
Type 2 Diabetes Screening	Asymptomatic adults with blood pressure higher than 135/80 mmHg
COVERED SERVICES FOR WOMEN	
Contraceptive Services (all services require a prescription for coverage) – • Education and Counseling related to contraceptives and sterilization • Barrier Contraceptive Method – Diaphragm, Sponge, Cervical Cap, Cervical Shield, Female Condom • Emergency Contraceptive Method (Prescription Drug Benefit) • Hormonal Contraceptive Method (Prescription Drug Benefit) – Generics, Single Source Brand if generic equivalent is not available • Implantable Contraceptive Method – IUD, Implantable Rods • Sterilization Method – Tubal Ligation, Essure *NOTE: Services may not apply for members of religious employer groups.*	Women with reproductive capacity: Ages 15 – 46
BRCA Genetic Testing – Screening and Counseling **NEW – BRCA Genetic Test will be covered for plans issued or renewed on or after 1/1/2015**	Women with family history of risk (per guidelines)
Breast Feeding Intervention	During pregnancy and after birth
Chemoprevention Counseling	Women at risk for breast cancer
Chlamydia Infection Screening	Women ages 24 and younger who are sexually active; older if at increased risk
Generic Folic Acid Supplements (Prescription Drug Benefit) – 0.4mg to 0.8mg/day	Women who are planning or capable of pregnancy: Ages 15 – 44
Gonorrhea Screening	Sexually active women
Human Papillomavirus (HPV) DNA testing – Limit of one (1) every three (3) years, with all other testing processing according to standard Benefits	Ages 30 and older
Intimate Partner Violence Screening	Ages 14 – 46

Lactation Counseling	During pregnancy and after each birth
Lactation Supplies for Machine Use Only	During the postpartum period
Mammography Examination	Ages 35 – 39: Baseline Ages 40 – 49: 1 every 24 months or as doctor prescribes Ages 50 and older: 1 every 12 months
Manual Breast Pump	During the postpartum period
Medications for Risk Reduction of Primary Breast Cancer	Asymptomatic Women: Ages 35 years or older without a prior diagnosis of breast cancer and who are at increased risk for breast cancer
Osteoporosis Screening: One (1) per Benefit Period	Ages 65 or older Younger women at risk (per guidelines)
Routine Pap Smear – One (1) per Benefit Period	Ages 21 – 65
Routine Gynecologist or Obstetrician Visits	As age and developmentally appropriate
Violence and Domestic Abuse Counseling	Women and adolescents, as needed
COVERED SERVICES FOR PREGNANT WOMEN	
Anemia Screening	During pregnancy
Bacteriuria Screening	During 12 – 16 weeks of gestation or at first prenatal visit
Gestational Diabetes Testing and Screening	During 24 – 28 weeks of gestation or at first prenatal visit if at high risk Asymptomatic pregnant women after 24 weeks of gestation

Rh Incompatibility Screening	Pregnant women during 24 – 28 weeks of gestation if at risk or at first prenatal visit
COVERED SERVICES FOR CHILDREN	
Alcohol and Drug Use Assessments	Ages 11 – 21
Autism Screening	Ages 1 – 2
Behavioral Assessments	Ages 0 – 21
Cervical Dysplasia Screening	Adolescent Girls: Ages 11 - 21
Congenital Hypothyroidism Screening	Newborns
Developmental Screening	Varied Intervals: Ages 0 – 3
Dyslipidemia Screening	Varied intervals beginning at 24 months
Fluoride (oral supplementation, application) **NEW – Fluoride Varnish Application: Effective for plans issued or renewed on or after 5/1/2015**	Ages 6 months – 5 years Infants and children at primary teeth eruption
Gonorrhea Prophylactic Ocular Medication	Newborns
Hearing Screening: One (1) per Benefit Period.	Ages 0 – 21
Height, Weight and Body Mass Index Measurements	Ages 2 – 21
Hematocrit or Hemoglobin Screening	Varied intervals: Ages 4 months – 21 years
Iron Supplement	Asymptomatic 6 – 12 months old if at risk
Lead Screening: One (1) per Benefit Period	Ages 0 – 6
Obesity Screening and Counseling	Ages 6 and older
Oral Health Assessment	Varied intervals between 6 months – 6 years
Phenylketonuria (PKU)	Newborns
Sickle Cell Screening	Newborns
Tuberculosis Screening: One (1) per Benefit Period	Ages 0 – 21
Vision Screening: One (1) per Benefit Period	Ages 0 – 21

ARTICLE IX. MENTAL HEALTH BENEFITS

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

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

ARTICLE X. SUBSTANCE ABUSE BENEFITS

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

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

ARTICLE XI. ORAL SURGERY BENEFITS

Coverage is provided only for the following services or procedures. The highest level of benefits are available when services are performed by a Network Provider, or by a Provider in the Blue Cross and Blue Shield of Louisiana's dental network. Access the dental network online at **www.bcbsla.com**, or call the customer service telephone number on Your ID card for a copy of the directory.

A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.

B. Extraction of impacted teeth.

C. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.)

D. Excision of exostoses or tori of the jaws and hard palate.

E. Incision and drainage of abscess and treatment of cellulitis.

F. Incision of accessory sinuses, salivary glands, and salivary ducts.

G. Anesthesia for the above services or procedures when rendered by an oral surgeon.

H. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.

I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Plan Participant's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia benefits are not available for treatment rendered for Temporomandibular Joint (TMJ) Disorders.

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

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

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

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

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) for the specific organ or transplant or a Blue Cross and Blue Shield of Louisiana (BCBSLA) Preferred network provider facility, unless otherwise approved by the Claims Administrator in writing. To locate a BDCT or BCBSLA Preferred network provider facility, Plan Participants should contact the Claims Administrator's customer service department at the number listed on their ID card.

2. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

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

C. Solid Human Organ Transplants

1. liver;

2. heart;

3. lung;

4. kidney;

5. pancreas;

6. small bowel; and

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

D. Tissue Transplant Procedures (Autologous and Allogeneic)

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

These following tissue transplants are covered:

1. blood transfusions;

2. autologous parathyroid transplants;

3. corneal transplants;

4. bone and cartilage grafting;

5. skin grafting;

6. autologous islet cell transplants; and

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

E. Bone Marrow Transplants

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

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

ARTICLE XIII. PREGNANCY AND NEWBORN CARE BENEFITS

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

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

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

A. Pregnancy Care

1. Medical and Surgical Services.

   a. Initial office visit and visits during the term of the pregnancy.

   b. Diagnostic Services.

c. Delivery, including necessary pre-natal and post-natal care.

d. Medically Necessary abortions required to save the life of the mother.

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

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

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

1. Medical and surgical services rendered by a Physician, for treatment of illness, pre-maturity, post-maturity, or congenital condition of a newborn and circumcision. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.

2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, pre-maturity, post-maturity, or congenital condition of a newborn. Charges for a well newborn, which are billed separately from the mother's Hospital bill, are not covered. The Hospital (nursery) charge for a well newborn is included in the mother's Hospital bill for the covered portion of her Admission for Pregnancy Care.

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

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

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

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

ARTICLE XIV. REHABILITATIVE / HABILITATIVE CARE BENEFITS

Rehabilitative and Habilitative Care Benefits will be available for services provided on an Inpatient or Outpatient basis:

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

Benefits are available when the therapy is rendered by a Provider licensed and practicing within the scope of his license. The Plan Participant must be able to tolerate a minimum of three (3) hours of active therapy per day.

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

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

Benefits under this Article are in addition to, but not a duplication of, the Benefits provided under any other provision of this Benefit Plan. Any Benefits provided under any other provision of this Benefit Plan will not be eligible Benefits under this Article.

A. Occupational Therapy

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

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

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

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

B. Physical Therapy

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

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

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

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

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

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

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

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

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

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered when performed by a Provider licensed to practice in the state in which the services are rendered and practicing within the scope of his license, including, but not limited to, a speech pathologist or by an audiologist.

2. The therapy must be used to improve or restore speech language deficits or swallowing function.

3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to the receipt of services.

D. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.

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

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

ARTICLE XV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. Accidental Injury Benefits

For the accidental injury of an Employee occurring while said Employee is performing the duties of his job, the Plan will pay, not subject to the Deductible, one hundred percent (100%) of the Allowable Charge of the Eligible Medical Expenses, subject to the limitations and exclusions of the Plan. No benefits will be paid for any services rendered after the date coverage ends.

B. Ambulance Service Benefits

1. Ground Ambulance Transport Services

   a. Emergency Transport

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

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

      (2) for the Newly Born Infant, to the nearest Hospital or neonatal Special Care Unit for treatment of illnesses, injuries, congenital birth defects and complications of premature birth which require that level of care;

      (3) for the Temporarily Medically Disabled Mother of an ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.

b. Non-Emergency Transport

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

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

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

(2) unable to ambulate; and

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

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

2. Air Ambulance Transport Services

a. Emergency Transport

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

b. Non-Emergency Transport

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

3. Ambulance Service Benefits will be provided as follows:

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

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

c. No Benefits are available if transportation is provided for a Plan Participant's comfort or convenience, or when a Hospital transports Plan Participants between parts of its own campus.

C. Attention Deficit/Hyperactivity Disorder

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

D. Autism Spectrum Disorders (ASD)

ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Habilitative and Rehabilitative Care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Plan Participants who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis when the Claims Administrator determines it is Medically Necessary. Applied Behavior Analysis is not covered for Plan Participants age twenty-one (21) and older.

E. Bone Mass Measurement

Benefits are available for scientifically proven Bone Mass Measurement tests for the diagnosis and treatment of osteoporosis if a Plan Participant is a woman age sixty (60) or older and:

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

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

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

Deductible, Coinsurance and/or Copayment amounts are applicable.

One (1) osteoporosis screening per Benefit Period is available to women age 65 and older, under the "Preventive or Wellness Care" Article of this Benefit Plan, at no cost to Plan Participants receiving care from a Preferred Provider.

F. Breast Reconstructive Surgery Services

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

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

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

   c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.

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

G. Clinical Trial Participation

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

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

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

   b. And either,

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

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

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

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

        (1) The National Institutes of Health.

        (2) The Centers for Disease Control and Prevention.

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

        (4) The Centers for Medicare & Medicaid Services.

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

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

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

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

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

        (1) The Department of Veterans Affairs.

        (2) The Department of Defense.

        (3) The Department of Energy.

4. The following services are not covered:

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

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

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

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

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

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

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

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

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

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

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

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

H. 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 routine 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 the Claims Administrator to be Investigational. This benefit is limited to men and women age fifty (50) to seventy-five (75) and other limitations shown in the Schedule of Benefits.

I. Diabetes Education and Training for Self-Management

Please refer to Your Schedule of Benefits for Annual Maximums.

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

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

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

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

J. Dietitian Visits

Benefits are available for visits to registered dietitians.

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

K. Disposable Medical Equipment or and Supplies

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

L. Durable Medical Equipment and Prosthetic Appliances

1. Durable Medical Equipment when required for treatment of an illness or injury when:

   Certificate is submitted in writing to the Plan by the Physician as to the medical necessity for the equipment and the anticipated length of time the equipment will be required for therapeutic use. The plan will pay for either the rental or the purchase of the equipment not to exceed the cost of the equipment. The Plan will not replace equipment that has been lost or damaged due to neglect or use not recommended by the manufacturer. Periodic recertifications may be required by the plan to determine the continued medical necessity of the equipment.

2. Prosthetic appliances, such as a manufactured hip joint or the initial purchase of an artificial leg or arm, for treatment of conditions caused only by accidental injury or illness occurring on or after the effective date of this Plan including the purchase of an initial implanted lens, contact lens, or corrective lens when such is being used to replace the natural lens removed as a result of injury or disease. For the purposes of this Plan, hearing aids, contact lens and/or corrective lens, for any purpose other than those stated above, are excluded.

M. Home Health Care Benefits

Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission and approved by the Claims Administrator's case management are covered.

N. Hospice Benefits

Hospice Care is covered.

There is a lifetime limit of six (6) months for hospice care, and it must be approved by the Plan's Claims Administrator prior to Admission to the facility.

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

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

1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. MethylmalonicAcidemia (MMA)
4. IsovalericAcidemia (IVA)
5. Propionic Acidemia
6. GlutaricAcidemia
7. Urea Cycle Defects
8. Tyrosinemia

P. Permanent Sterilization Procedures and Contraceptive Devices

Benefits are available for surgical procedures that result in permanent sterilization, including vasectomy.

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

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

Q. Private Duty Nursing Services

Coverage is available to a Plan Participant for Private Duty Nursing Services when performed on an Outpatient basis and when the nurse is not related to the Plan Participant by blood, marriage or adoption.

Private Duty Nursing Services are subject to the Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

Inpatient Private Duty Nursing Services are not covered.

R. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Only sleep studies performed in the home or sleep studies performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM) are eligible for coverage.

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

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

2. High Tech Imaging, including but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology, are subject to Deductible and Coinsurance. These services require prior Authorization.

ARTICLE XVI. CARE MANAGEMENT

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

1. Selection of Provider

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

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

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

b. If the Claims Administrator does approve the use of a Non-Network Provider, that Provider may or may not accept the Plan Participant's Inpatient Hospital Copayment Amount at the time services are rendered. The Plan will pay Benefits up to the Allowable Charge for Covered Services rendered by an approved Non-Network Provider who has obtained any required Authorizations prior to services being rendered. The Claims Administrator will deduct from payment the amount of the Plan Participant's Inpatient Hospital 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.

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

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

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

a. Admissions

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

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

(3) The Plan Participant remains responsible for his Inpatient Hospital Copayment Amount, or any applicable Deductible amount and Coinsurance percentage.

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

b. Outpatient Services, Other Covered Services and Supplies

(1) If a Network Provider fails to obtain a required Authorization, the Network Provider is responsible for all charges not covered.

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

(3) The Plan Participant remains responsible for any applicable Copayment amount, or any applicable Deductible amount and Coinsurance percentage.

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

3. Authorization of Admissions

a. Authorization of Elective Admissions

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

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

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

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

b. Authorization of Emergency Admissions

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

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

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

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

c. Concurrent Review

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

that day. If the Claims Administrator Authorized the request, the Claims Administrator will again Authorize a certain number of days, repeating this procedure until the Plan Participant is either discharged or the Plan Participant's continued stay request is denied.

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

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

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

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

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

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

b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, the Plan will have the right to determine if the services and supplies were Medically Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider.

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

5. Appeals

a. If either the Plan Participant or the Provider disagrees with the denial of any Authorization, the denial may be appealed as shown in the Complaints, Grievance and Appeals article of this Benefit Plan. The Plan Participant or the Provider may Appeal the denial by contacting the Claims Administrator in writing within one hundred eighty (180) days of notice of the denial in accordance with the Complaints, Grievance and Appeals article of this Benefit Plan.

b. If the Claims Administrator does not reverse the decision, the Plan Participant will be responsible for (and no Benefits will be payable for) charges incurred.

c. Providers will be notified of Appeal results only if the Provider filed the Appeal.

B. Disease Management

1. Qualification

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

2. Disease Management Benefits

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

C. Case Management

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

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

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

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

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

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

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

D. Alternative Benefits

1. The Plan Participant may qualify for Alternative Benefits, at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and

families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Plan Participant and to the Group.

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

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

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

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

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

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

ARTICLE XVII. LIMITATIONS AND EXCLUSIONS

A. Services, supplies and treatment for services that are not covered under this Plan and complications from services, supplies and treatment for services that are not covered under this Plan are excluded.

B. Any of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown in the Schedule of Benefits, or elsewhere in this policy. Unless otherwise shown as covered in the Schedule of Benefits, the following are not covered, **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**

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

    2. Any charges exceeding the Allowable Charge.

    3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.

    4. Services, Surgery, supplies, treatment, or expenses:

        a. other than those specifically listed as covered by this Plan. Benefits are not payable for services a Plan Participant has no obligation to pay, or for which no charge or a lesser charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions;

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

c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license;

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

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

f. Workers' Compensation and injuries as a result of riots or civil disobedience are not exclusions for the Employee only while on duty. These remain exclusions for Employees off duty and for Dependents at all times;

g. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; or

h. rendered by a Provider who is the Plan Participant's spouse, child, stepchild, parent, stepparent or grandparent.

5. Services in the following categories:

a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;

b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;

c. those occurring as a result of taking part in a riot or acts of civil disobedience;

d. for treatment of any Plan Participant confined in a prison, jail, or other penal institution; or

e. those occurring as a result of a Plan Participant's commission or attempted commission of a felony. This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Member for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or in case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition.

6. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**

a. rhinoplasty;

b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;

c. gynecomastia;

d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Benefit Plan;

e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants, except for breast reconstructive services as specifically provided in this Benefit Plan;

f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;

g. diastasis recti;

h. biofeedback;

i. lifestyle/habit changing clinics and/or programs, except those offered, endorsed, approved, or promoted by the Plan Administrator, which may be part of your health care coverage under this Benefit Plan, or which may be a value-added program subject to minimal additional cost to You, should You voluntarily choose to participate in the program;

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

k. industrial testing or self-help programs including, but not limited to stress management programs, work hardening programs and/or functional capacity evaluation; driving evaluations, etc.;

l. recreational therapy;

m. primarily to enhance athletic abilities; and/or

n. Inpatient pain rehabilitation and pain control programs.

7. Services, Surgery, supplies, treatment, or expenses related to:

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

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

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

   c. the transplant of any non-human organ or tissue; or

   d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.

9. Regardless of Medical Necessity services, Surgery, supplies, treatment or expenses related to:

   a. weight reduction programs;

   b. removal of excess fat or skin, or services at a health spa or similar facility; or

   c. obesity or morbid obesity.

10. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.

11. Prescription Drugs that the Claims Administrator determines are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits:

    a. Lifestyle-enhancing drugs including but not limited to medications used for:

        - cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®),
        - hair loss or restoration (e.g., Propecia®, Rogaine®),
        - effects of aging on the skin,
        - weight loss (e.g., Xenical®),
        - enhancing athletic performance.

    b. Any medication not proven effective in general medical practice.

    c. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug.

    d. Fertility drugs.

    e. Nutritional or dietary supplements, or herbal supplements and treatments.

    f. Prescription vitamins not listed as covered in the Prescription Drug Formulary (including but not limited to Enlyte).

    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, except those required to be provided for preventive services recommendations.

    h. 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.

    i. 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.

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

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

l. Prescription Drugs related to a non-Covered Service.

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

n. 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.

o. Growth hormone therapy, except for treatment of chronic renal insufficiency, AIDS wasting, Turner Syndrome, Prader-Willi syndrome, Noonan Syndrome, wound healing in burn patients, growth delay in patients with severe burns, short bowel syndrome, short stature homeobox-containing gene (SHOX) deficiency, or growth hormone deficiency when a Physician confirms growth hormone deficiency with abnormal provocative stimulation testing.

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

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

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

See the Schedule of Benefits for additional information regarding Prescription Drug coverage, limitations and/or exclusions.

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

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

13. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Plan Participant's Coinsurance and 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 Plan Participant's Copayment, in which case, the Plan Participant must pay the Prescription Drug cost and sales tax.

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

15. Charges for the delivery of health care, diagnosis, consultation, or treatment of a Plan Participant, unless the Provider is physically present with the Plan Participant at the time services are rendered, are not covered unless approved by the Claims Administrator. Covered Services delivered using technology, including but not limited to audio and video transmission, telephone, or email may be subject to Authorization as shown in the Schedule of Benefits.

16. Charges for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

17. 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.

18. Any abortion other than to save the life of the mother.

19. 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.

20. 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.

21. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.

22. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered Services.

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

24. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits.

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

    a. malocclusion;

    b. Temporomandibular/Craniomandibular Joint Disorder,

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

    d. any orthognathic condition.

26. 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.

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

28. Educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities, including dyslexia. This exclusion for educational services and supplies does not apply to training and education for diabetes.

29. 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.

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

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

32. Hospital charges for a well newborn.

33. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.

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

35. Surgical and medical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).

36. Paternity tests and tests performed for legal purposes.

37. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant.

38. Reversal of a voluntary sterilization procedure.

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

40. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.

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

42. Sleep studies, unless performed in the home or performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM). If a sleep study is performed in a sleep laboratory that is not accredited by one of these bodies, or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.

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

ARTICLE XVIII. CONTINUATION OF COVERAGE

A. COBRA Continuation

The following provisions are applicable only if the Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto. Please refer to the Group Human Resources Manager or Benefits Manager for details about COBRA, or the applicability of COBRA to this Benefit Plan.

What is COBRA continuation coverage?

In accordance with COBRA law, the employees and eligible dependents of certain employers may have the opportunity to continue their employer-sponsored healthcare coverage for a limited time, when there is a life event (also known as a “qualifying event”) that would otherwise result in the loss of coverage under the employer’s plan. When a qualifying event causes such loss of coverage, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” The Plan Participant, the Plan Participant’s spouse and his Dependent children are listed under the law as the qualified beneficiaries. COBRA continuation coverage offers the same coverage that the Plan gives to other Plan Participants or beneficiaries who are not receiving continuation coverage. The qualified beneficiary may be required to pay the full cost of the continuation coverage for its entire duration.

Do I have other alternatives to COBRA continuation coverage?

COBRA continuation coverage is not the only alternative Plan Participants may have when they lose coverage under this Benefit Plan. There may be other coverage options for You and Your family.

For example, You could qualify to buy individual coverage through the Health Insurance Marketplace. Losing coverage under this Benefit Plan gives You a special enrollment opportunity in the Marketplace, even when it happens outside of the Marketplace's open enrollment period. You have sixty (60) days from when You lose coverage under this Benefit Plan to apply for special enrollment through the Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special enrollment opportunity for the Marketplace, and You will not be able to enroll until the Marketplace's normal enrollment period opens or Your COBRA continuation coverage is exhausted.

Additionally, You may qualify for a special enrollment opportunity for another group health plan for which You are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if You request enrollment within thirty (30) days from losing coverage under this Benefit Plan.

You should consider all Your options in order to choose the one that best fits Your needs and budget.

What if I choose to get COBRA continuation coverage?

If You and Your Dependents are qualified beneficiaries and choose to get COBRA continuation coverage, You must follow all notice and time period requirements described below or You will lose Your rights. If the Group requires shorter time periods than those stated herein, the shorter time periods of the Group apply.

What are the "qualifying events"?

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 Employee;
- death of a covered Employee;
- divorce or legal separation between a covered Employee and his/her spouse;
- the covered Employee becomes entitled to Medicare Benefits resulting in the loss of coverage for Dependents;
- a Dependent child ceases to be an eligible Dependent under the terms of this Benefit Plan; or
- the Employer files for a Chapter 11 bankruptcy proceeding, but only with respect to covered former Employees who retired from the Employer at any time.

NOTE: Special rules apply for certain retirees and their Dependents who lose coverage because of an employer's Chapter 11 bankruptcy. In this event, certain retirees may elect lifetime COBRA coverage. 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. COBRA continuation coverage rights under Chapter 11 bankruptcy

proceedings will be determined by the bankruptcy court, and the coverage eligible beneficiaries could receive may not be the same as the ones they had under the retiree plan before the employer filed for Chapter 11 bankruptcy.

Do I have to provide notification of any qualifying event?

The qualified beneficiary must give notice of the following qualifying events to the Group within 60 days of the event:

- divorce or legal separation,
- becoming entitled to Medicare, or
- a Dependent losing eligibility for coverage as a Dependent child.

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

What do I have to do to get COBRA continuation coverage?

To elect continuation coverage, the qualified beneficiary must complete a COBRA election form and furnish it to the Group timely. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Plan Participant would otherwise lose coverage under the Group health plan (the "coverage end date"); and
- ends sixty (60) days after the coverage end date or sixty (60) days after the Plan Participant is notified of their right to continue coverage, whichever is the latest.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the Employee's spouse may elect continuation coverage even if the Employee does not. Continuation coverage may be elected for only one, several or for all Dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of the Dependent children. The Employee or the Employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

How much will I have to pay for COBRA continuation coverage?

A Plan Participant may be required to pay the entire cost of continuation coverage (including both Employer and Employee contributions) plus an amount to cover administrative expenses. If continuation of coverage is elected, the qualified beneficiary must make his first payment for continuation coverage within forty-five (45) days after the date of the election. If the qualifying beneficiary does not make the correct first payment in full within the forty-five (45) day period, all COBRA continuation coverage rights are lost. Timely monthly payments are required thereafter to keep coverage. Plan Participants may not receive notice of payments due.

When will COBRA continuation coverage begin and how long will it last?

Once elected, COBRA continuation of coverage will begin on the coverage end date and will terminate on the earliest of the following events:

- eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the Employee became entitled to Medicare benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified beneficiaries other than the Employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or
- thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or
- the date the Employer ceases to maintain any Group health plan for its Employees; or

- the date coverage ceases because of nonpayment of required premiums when due; or
- the date the qualified beneficiary first becomes covered under another group health plan and benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (NOTE: There are limitations on plans imposing Pre-Existing condition exclusions and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).; or
- the date the qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

Can I extend my COBRA continuation coverage?

A qualified beneficiary's right to COBRA continuation coverage will never last longer than thirty-six (36) months from the qualifying event. This maximum duration period cannot be extended, regardless of the circumstances.

Those that are receiving eighteen (18) months of continuation coverage can extend their period, as explained below, if they undergo a second qualifying event during that original eighteen (18) month period, or are declared disabled by the Social Security Administration.

If a qualified beneficiary experiences a second qualifying event other than the termination of employment or reduction of work hours while receiving eighteen (18) months of COBRA continuation of coverage, the Dependents who were qualified beneficiaries at the time of the first qualifying event, and elected COBRA continuation coverage, may qualify for up to eighteen (18) additional months of continuation of coverage, for a maximum of thirty-six (36) months. This extension may be available to Dependents receiving continuation of coverage if:

- the Employee or former Employee dies;
- the Employee or former Employee becomes entitled to Medicare (under Part A, Part B, or both);
- the Employee or former Employee and Dependent spouse divorce;
- 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. Qualified beneficiaries must notify the Group within sixty (60) days after a second qualifying event to extend the COBRA continuation coverage.

The eighteen (18) months of continuation coverage may also be extended to a maximum of twenty-nine (29) months if a qualified beneficiary is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) by the Social Security Administration before the first day of COBRA coverage, or is declared 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 and elected COBRA continuation coverage for the original eighteen (18) months. 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 notice from the Social Security Administration of the determination of disability; or
- the date of the qualifying event.

The qualified beneficiary must also notify the Group within thirty (30) days of any final determination by the Social Security Administration 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, subject to the original eighteen (18) months of COBRA coverage.

Keep Your Plan Informed of Address Changes

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

B. Employee Rights Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

Employees going on a military leave of absence to perform "service in the United States uniformed services" (as that term is defined under USERRA) may elect to continue coverage under this Benefit Plan for up to 24 months from the date that the Employee leaves for service. Only a covered Employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the Plan immediately before him/her leaving for military service. Dependents do not have any independent right to elect USERRA continuation coverage.

To claim USERRA continuation coverage, the Employee must properly notify the Employer that he/she is leaving to perform "service in the uniformed services" and apply for continuation coverage as required by the Employer.

An Employee who elects USERRA continuation coverage may be required to pay a premium. If the leave of absence lasts thirty (30) days or less, the Employee may be required to pay the Employee's required contribution for coverage. However, if the military leave of absence lasts more than thirty (30) days, the Employee may be required to pay up to 102% of the full contribution under the Plan (including both, the Employer's and the Employee's contribution for coverage).

USERRA continuation coverage may be terminated before the maximum 24 month period if:

1. The Employee fails to pay the required premiums timely, or

2. The day after the date on which the Employee is required under the law to apply for or return to a position of employment and fails to do so.

USERRA continuation coverage rights may be provided concurrently with COBRA continuation coverage, as allowed by law.

If You wish to elect this coverage or obtain more detailed information, contact the Plan Administrator.

ARTICLE XIX. COORDINATION OF BENEFITS

A. All benefits provided under the medical program are subject to this provision. This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan, and under all other plans covering an individual, exceed the allowable expenses incurred during a claim determination period.

B. The coordination of benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

C. Determination of Benefits

1. One of the two or more plans involved is the primary plan and the other plans are secondary plans. The primary plan pays benefits first and without consideration of the other plans. The secondary plans then make up the difference up to the total allowable expenses.

2. No plan will pay more than it would have paid without this special provision. If one plan has no coordination of benefits provision, it is automatically primary.

3. The rules for establishing the order of benefit determinations are:

    a. A plan may be primary if it covers the individual as an Employee and secondary if it covers the individual as a Dependent.

    b. When a Child is covered as a Dependent under two or more plans:

        (1) The plan of the parent whose birth date (month and day, not year) occurs earlier in the calendar year pays its benefits before the other parent's plan, and

        (2) If one of the plans does not contain the provisions stated in (a) above, the plan of the male parent will pay its benefits before the plan of the female parent.

        (3) When the parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of the plan which covers the Child as a Dependent or the parent with custody of the Child will be determined before the benefits of the plan which covers the Child as a Dependent of the parent without custody.

        (4) When the parents are divorced and the parent with custody of the Child has remarried, the benefits of the plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits or the plan covering the Child as a Dependent of the step-parent, and the benefits of the plan covering the Child as a Dependent of the step-parent will be determined before the benefits of the plan covering that Child as a Dependent of the parent without custody.

        (5) Notwithstanding (a) and (b) above, if there is a court decree which would otherwise establish financial responsibility for the Health Care expenses incurred by the Child, the benefits of the plan covering the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan covering the Child as a Dependent Child.

    c. When an individual is covered under two or more plans as an active and retired or laid-off Employee:

        (1) The plan covering the individual as an active Employee (or Dependent of an active Employee) will be primary, and the plan covering the individual as a retired or laid-off Employee (or Dependent of a retired or laid-off Employee) will pay secondary benefits.

        (2) If one of the plans does not contain the provision stated in (a) above, the primary plan will be the plan that has covered the individual for the longer period of time.

4. When the total amount of benefits otherwise payable under this Plan during any claim determination period is reduced in accordance with this provision, each benefit that would be payable in absence of this provision shall be reduced either proportionately or in such other equitable manner as the Third Party Administrator shall determine and such reduced amount shall be charged against any applicable benefit limit of this Plan.

5. "Other Plan" as used herein means the following plans providing benefits or services for or by reason of medical or dental care or treatment: (1) Group insurance or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis; or (2) Any coverage for students which is sponsored by, or provided through, a school or other educational institution.

6. "Claim Determination Period" as used herein means calendar year.

7. "Allowable Expenses" as used herein means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one (1) of the plans covering the person for whom claim is made.

ARTICLE XX. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

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

A. The Benefit Plan

1. Except as specifically provided herein, this Benefit Plan will not make the Claims Administrator liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the Plan Administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those specifically undertaken by Us herein. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group's failure to do so.

2. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.

3. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.

4. The (Plan Administrator) shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, health care Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

B. Amending and Terminating the Benefit Plan

The Employer intends to maintain this Benefit Plan indefinitely; however, it reserves its right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the Benefits under the plan or the trust agreement, if any.

C. Identification Cards and Benefit Plans

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

D. Benefits Which Plan Participants are Entitled

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

E. Termination of a Plan Participant's Coverage

1. The Plan may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form or intentionally omitted there from, as to any proposed or covered Plan Participant, shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective date of coverage or terminated within three (3) years of the Plan Participant's Effective Date, for fraud or intentional misrepresentation of material fact. The Plan will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section

2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, an Employee's coverage terminates as provided below:

    a. The Employee's coverage and that of all his Dependents automatically, and without notice, terminates at the date of the termination date.

    b. The coverage of the Employee's spouse will terminate automatically, and without notice the date of a final decree of divorce or other legal termination of marriage.

    c. The coverage of a Dependent will terminate automatically, and without notice, the date the Dependent ceases to be an eligible Dependent.

    d. Upon the death of an Employee, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if Employee contributions have been paid through that period the date that death occurred. However, a surviving spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.

3. In the event the Group cancels this Benefit Plan, such cancellation or termination alone will operate to terminate all rights of the Plan Participant to Benefits under the terms of this Benefit Plan as of the effective date of such cancellation or termination. The Group shall have the obligation to notify its Plan Participants and beneficiaries of such cancellation or termination. The Claims Administrator shall have no such obligation of notification at the Plan Participant level.

4. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Plan Participant for Covered Services rendered after the date of termination of a Plan Participant's coverage.

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

F. Filing Claims

1. A Claim is a written or electronic proof of charges for Covered Services that a Plan Participant has incurred during the time-period he was covered under this Plan. The Plan encourages Providers to file Claims in a form acceptable to the Claims Administrator within ninety (90) days from the date services are rendered, but no later than twenty four (24) months after the date of service. Contract provisions in effect at the time the service or treatment is received shall govern the processing of any Claim filed or expense actually incurred as a result of the service or treatment rendered. Written proof of claim must be given to the

Claims Administrator by the end of the calendar year following the year in which the expense was incurred. However, when an Employee's coverage terminates for any reason, written proof of claim must be given to the Plan Administrator within ninety (90) days of the date of termination of coverage, provided that the Plan remains in force.

2. Failure to furnish notice or proof within the time provided shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice of proof and that such notice or proof was furnished as soon as was reasonably possible.

3. Most Plan Participants that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Plan Participant. However, if the Plan Participant must file a Claim to access his Prescription Drug Benefit, the Plan Participant must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to the Claims Administrator, may require the signature of the dispensing pharmacist. The claim form should then be sent to the Claims Administrator's pharmacy benefit manager, whose telephone number can be found on the Plan Participant's ID card.

G. Applicable Law

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

H. Time Limit for Legal Action

No lawsuit may be filed

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

I. Release of Information

The Claims Administrator may request that the Plan Participant or the Provider furnish certain information relating to the Plan Participant's Claim for Benefits. The Claims Administrator will hold such information, records, or copies of records as confidential except where in the Claims Administrator's discretion the same should be disclosed.

J. Assignment

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

2. The Plan reserves the right to pay Preferred Providers directly instead of paying the Plan Participant.

K. Plan Participant/Provider Relationship

1. The choice of a Provider is solely the Plan Participant's.

2. The Claims Administrator and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. The Claims Administrator does not render Covered Services, but only makes payment, on behalf of the Plan,

for Covered Services for which the Plan Participant receives. Neither the Plan nor the Claims Administrator will be held liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any Network Provider or in any Network Provider's facilities. The Plan and the Claims Administrator have no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.

3. The use or non-use of an adjective such as Preferred Network, Participating, and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

L. This Benefit Plan and Medicare

1. For Employers having twenty (20) or more active Employees, federal law and regulations require that each active Employee age sixty-five (65) or older, and each active Employee's spouse age sixty-five (65) or older, may elect to have coverage under this Plan or under Medicare.

   a. Where such Employee or such spouse elects coverage under this Plan, this Plan will be the primary payor of Benefits with the Medicare program the secondary payor.

   b. This Plan will not provide Benefits to supplement Medicare payments for Medicare eligible expenses for an active Employee age sixty-five (65) or older or for a spouse age sixty-five (65) or older of an active Employee where such Employee or such spouse elects to have the Medicare program as the primary payor.

2. Under federal law, if an active employee under age sixty-five (65) or an active employee's dependent under age sixty-five (65) is covered under a group benefit plan of an employer with one hundred (100) or more employees and also has coverage under the Medicare program by reason of Social Security disability, the group benefit plan is the primary payor and Medicare is the secondary payor.

3. For persons under age sixty-five (65) who are covered under this Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Plan the secondary payor, except that during the first thirty (30) month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, this Plan will be the primary payor and Medicare the secondary payor.

4. When this Plan is the primary payor, it will provide regular Benefits for Covered Services.

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

M. Notice

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

N. Job-Related Injury or Illness

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

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

O. Subrogation

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

2. The Plan Participant will reimburse the Plan all amounts recovered by suit, settlement, or otherwise from any third party or the Plan Participant's insurer to the extent of the Benefits provided or paid under the Plan. The Plan's right to reimbursement comes first even if the Plan Participant is not paid for all of the Plan Participant's Claim for damages or even if the payment the Plan Participant receives is for, or is described as for, the Plan Participant's damages other than health care expenses, or if the Plan Participant recovering the money is a minor. All costs that the Plan Participant incurs (including attorney fees) in exercising any right of recovery will be the Plan Participant's responsibility. Amounts that We paid on behalf of the Plan for which a third party or insurer is responsible will not be reduced by the amount of the Plan Participant's costs. The Plan Participant shall hold in trust for the account of the Plan all amounts recovered, up to the total amount of Benefits paid. The Plan appoints the Plan Participant as its representative for such limited purpose only.

3. The Plan Participant will take such action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of the Plan's rights, and will take no action prejudicing the Plan's rights and interest under this Plan. The Plan and its designees have the right to obtain and review Plan Participant's medical and billing records, if the Plan or its designee determines in their sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits Article of this Benefit Plan.

4. The Plan Participant will notify the Plan of any Accidental Injury.

P. Right of Recovery

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

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

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

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

R. Liability of Plan Affiliates

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

S. Out-of-Area Services

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

Whenever Plan Participants access care outside Blue Cross and Blue Shield of Louisiana’s service area, Plan Participants will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Plan Participants may obtain care from non-participating healthcare providers. Claims Administrator’s payment practices in both instances are described below.

1. BlueCard® Program

   Under the BlueCard® Program, when Plan Participants access covered healthcare services within the geographic area served by a Host Blue, Claims Administrator will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   Whenever Plan Participants access covered healthcare services outside Blue Cross and Blue Shield of Louisiana’s service area and the claim is processed through the BlueCard Program, the amount Plan Participants pay for covered healthcare services from Participating Providers is calculated based on the lower of:

   - the billed covered charges for your covered services; or
   - the negotiated price that the Host Blue makes available to the Plan.

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

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

2. Medicare Supplemental/Medigap/Medicare Complementary

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

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

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

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

   a. Plan Participant Liability Calculation

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

   b. Exceptions

      In some exception cases, Claims Administrator may pay claims from non-participating healthcare providers outside of Blue Cross and Blue Shield of Louisiana's service area based on the provider's billed charge, the payment Claims Administrator would make if it were paying a non-participating provider inside of its service area (where the Host Blue's corresponding payment would be more than the Company's in-service area non-participating provider payment), or in Claims Administrator's sole and absolute discretion, it may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Plan Participant may be responsible for the difference between the amount that the non-participating healthcare provider bills and payment the Claims Administrator will make for the covered services as set forth in this paragraph.

   c. Medigap/Medicare Supplemental/Medicare Complementary Plans

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

4. Out-of-Area Claims: Non-Participating Providers Member Liability Calculation – Emergency Care

   If You need Emergency Medical Services in the emergency department of a Hospital, We will cover You at the highest level that the Patient Protection and Affordable Care Act and federal regulations require. You will have to pay for any charges that exceed the Allowable Charge as well as any Deductibles, Coinsurance and Copayments.

T. Certificates of Creditable Coverage

The Claims Administrator will issue a certificate of Creditable Coverage or similar document, upon request, to a Plan Participant within twenty-four (24) months after coverage under this Benefit Plan ceases.

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

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

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

1. prior to the Medicare Part D Annual Coordinated Election Period;

2. prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D;

3. whenever Prescription Drug coverage under this Benefit Plan ends;

4. whenever Prescription Drug coverage under this Plan changes so that it is no longer creditable or becomes creditable; and/or

5. upon a Medicare beneficiary's request.

V. Continued Coverage During a Leave of Absence

1. Family Medical Leave

   The Family Medical Leave Act (FMLA) allows eligible Employees to take up to twelve (12) weeks of unpaid FMLA leave in a 12-month period for the following reasons:

   a. a serious health condition that makes You unable to perform Your job;

   b. to care for a seriously ill dependent child, spouse or parent; or

   c. for the birth, placement for adoption or foster care of a child.

   A serious health condition is an illness, injury, impairment, or physical/mental condition involving either Inpatient care or continuing treatment by a health care Provider. Leave may be taken intermittently or on a reduced schedule only if Medically Necessary. If leave is taken on an intermittent basis, the arrangement must be agreed to in advance by the Employee and the Group. Certification of a serious health condition must be provided in writing to the Group. To be eligible for FMLA, an Employee must have completed twelve (12) months of employment and have worked at least 1,250 hours during the 12-month period preceding the leave requested.

   The Plan will continue coverage for Employee during any leave of absence the Group is required to provide by applicable federal or state law, including FMLA and any amendments or successor provisions, as long

as eligibility criteria under the law continues to be met. If Employee's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, Employee is entitled to re-enroll for coverage without being subject to otherwise applicable Pre-existing Condition Waiting Periods. If the Employee is not restored to active full-time employment by the end of the leave of absence period, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in "Termination of a Plan Participant's Coverage."

2. Disability Leave

When an Employee is not actively at work due to a health condition, Plan will maintain coverage for the Employee and any Dependents, as long as the Employee remains a bona fide Employee of the Group and required contributions are paid. If Group terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan Participant's Coverage."

3. Other Employer-Approved Leave of Absence

When an Employee has been granted a documented, approved leave of absence by the Employer, the Plan will maintain coverage for the Employee and any covered Dependents for a period not to exceed ninety (90) days. Employee must remain a bona fide Employee of the Group during the approved leave period. The Employer will provide the Claims Administrator with proof of the documented leave, upon request. If the Employer terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan Participant's Coverage."

W. Compliance with HIPAA Privacy Standards

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

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

1. General

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

2. Permitted Uses and Disclosures

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

3. Authorized Employees

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

a. Updates Required. The Employer shall amend the plan promptly with respect to any changes in the Employees of its workforce who are authorized to receive Protected Health Information.

b. Use and Disclosure Restricted. An authorized Employee of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

c. Resolution of Issues of Noncompliance. In the event that any Employee of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

(1) investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;

(3) mitigating any harm caused by the breach, to the extent practicable; and

(4) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Employer

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

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

b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Employer;

d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. ensure the adequate separation between the Plan and Employee of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

The following Employees of the Louisiana Sheriffs' Association's workforce are designated as authorized to receive Protected Health Information from Louisiana Sheriffs' Association Group Benefits Program ("the Plan") in order to perform their duties with respect to the Plan:

Michael Williams, Senior Benefits Consultant; Annette Dowdle, Senior Vice-President; Brenda Smith, Benefits Consultant; Kaelin Telschow, Marketing Analyst; Roxanne Valenti, Benefit Analyst; Jennifer Taffaro, Benefit Consultant; Valerie Cowart, Group Benefits Specialist; Roxie Lea, LSA Group Benefit Program Secretary; Ret. Sheriff Gary Bennett, Asst. Executive Director/Insurance Committee; Sheriff Mike Waguespack, Ch. Insurance Committee; Sheriff Mike Stone, Insurance Committee; Janelle Millet, Insurance Committee; Skip McGee, Insurance Committee; Ricky Edwards, Insurance Committee; Renee Brinkley, Insurance Committee; Mike Ranatza, Executive Director; James Bustillo, Regional Director/BCBSLA.

X. Compliance with HIPAA Electronic Security Standards

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

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections (3) Authorized Employees and (4) Certification of Employers described above in this Article.

Y. Reservation of Rights by the Employer and Limitations of Rights of Participants

1. Although it is the intention of the Employer that the Plan shall be continued and its contributions made regularly, the Plan is entirely voluntary on the part of the Employer and the continuance of the Plan and the payments thereunder are not assumed as a contractual obligation of the Employer.

2. This Plan shall not be deemed to constitute a contract between the Employer and any Plan Participant or to be a consideration or an inducement for the employment of any Plan Participant or Employee. Nothing contained in this Plan shall be deemed to give any Plan Participant or Employee the rights to be retained in the service of the Employer or to interfere with the right of the Employer to discharge the Plan Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Plan Participant of the Plan.

3. It is intended that the Plan shall be approved and qualified by the Internal Revenue Service as meeting the requirements of the Federal Internal Revenue Code and Regulations issued thereunder with respect to the Employee's Plans and Trusts so that contributions so made and the income of the Trust Fund shall be exempt from federal income tax. In the event the Commissioner of Internal Revenue or his delegate rules that the Plan set forth in this Agreement is not qualified, or a deduction for all or a part of the Employer's contribution is not allowed, the Employer reserves the right to recover that portion or all of its contribution for which no income tax exemption is allowed.

ARTICLE XXI. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The Claims Administrator wants to know when a Plan Participant is unhappy about the care or services received from the Claims Administrator or one of its Providers. Plan Participants may register a Complaint, or file a formal written Grievance about the Claims Administrator or a Provider by following the procedures outlined below.

Appeal rights for Plan Participants are outlined after the Complaint and Grievance Procedures. The Plan considers a Plan Participant's request to change a coverage decision as an Appeal. An Appeal is defined as a request from a Plan Participant or their authorized representative to change a previous decision made by the Claims Administrator about Covered Services. Examples of issues that qualify as Appeals include denied Authorizations, Claims denied based on adverse determinations of Medical Necessity, or other adverse Benefit determinations. Adverse Benefit determinations include denials of and reductions in Benefit payments.

In addition to the right to Appeal, a Plan Participant's Provider is given an opportunity to speak with a medical director for an Informal Reconsideration of the Claims Administrator's coverage decision when the coverage decision concerns Medical Necessity or Investigational determinations.

The Plan Participant may also have the right to review their file and present evidence or testimony as part of the internal Claims and Appeals process.

An Expedited Appeal process is available for situations where the standard time frames would seriously jeopardize the life or health of a covered person, jeopardize the covered person's ability to regain maximum function, or where in the opinion of the treating Physician, the covered person may experience pain that cannot be adequately controlled while awaiting a standard Appeal decision. That process is outlined following the first and second level Appeal procedures in Section B of this Article.
The Claims Administrator will respond to your Appeal request within the timeframes allowed by law. The Appeal response will provide information sufficient to identify the Claim and include the following:

- The date of service; health care Provider; Claim amount, if applicable; and diagnosis and treatment codes, and the corresponding meanings of these codes (provided upon request).

- A description of the reason(s) for the denial, including a description of the standard, if any, applied in denying the Claim (for example, if a Medical Necessity standard was used in denying a Claim, the notice will describe the Medical Necessity standard); and a discussion of the decision for final internal Benefit denials.

- A description of available internal Appeals and external review procedures, including information on how to initiate an Appeal.

- Contact information for available sources to assist Plan Participants with internal Claims, Appeals and external review procedures.

A. Complaint and Grievance Procedures

A quality of service concern addresses the Claims Administrator's services, access, availability or attitude and those of the Claims Administrator's Network Providers. A quality of care concern addresses the appropriateness of care given to a Plan Participant.

1. To Register a Complaint

Call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370. The Claims Administrator will attempt to resolve a Plan Participant's Complaint at the time of their call.

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with the Claims Administrator or with services rendered by a Provider. If a Plan Participant does not feel their Complaint was adequately resolved or the Plan Participant wishes to file a formal Grievance, the Plan Participant must submit this in writing within 180 days of the event that led to the dissatisfaction. Our Customer Service Department will assist the Plan Participant if necessary. The Claims Administrator's customer service department will assist the Plan Participant if necessary. Send written Grievances to:

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

A response will be mailed to the Plan Participant within thirty (30) business days after the Claims Administrator receives the written Grievance.

3. Informal Reconsideration

An Informal Reconsideration is an authorized Provider's telephone request to speak to the Claims Administrator's medical director or a peer reviewer about a Utilization Management decision that the Claims Administrator has made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

Informal Reconsideration is available only for initial determinations that are requested within ten (10) days of the denial or Concurrent Review determinations. The Claims Administrator will conduct an Informal Reconsideration within one (1) working day of the receipt of the request.

B. Appeal Procedures

If a Plan Participant is not satisfied with the Claims Administrator's denial of services, a written request to Appeal must be submitted within one hundred eighty (180) days following receipt of the initial adverse Benefit determination.

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

If the Plan Participant has questions or needs assistance putting the Appeal in writing, the Plan Participant may call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370.

Appeal Process

The Claims Administrator will distinguish a Plan Participant's Appeal as an administrative Appeal or a medical Appeal. The procedure has two (2) levels of Appeal, the first by the Claims Administrator or its designee, and the second by the Plan Administrator, Louisiana Sheriffs' Association Group Benefits Program. The Plan Participant is encouraged to provide Us with all available information to help Us completely evaluate the Plan Participant's Appeal.

The first level of all Appeals will be internal and the second level of administrative Appeals will also be internal. For Medical Necessity and Investigational Appeals, the second level will be handled by an external Independent Review Organization (IRO) that is not affiliated with Us. Any decision by an IRO is binding on both the Plan Participant and Us.

Plan Participants are encouraged to submit written comments, documents, records, and other information relating to the Claim for Benefits. Upon request by the Plan Participant and free of charge, we will provide reasonable access to and copies of all documents, records, and other information relevant to the covered person's Claim for Benefits.

The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in their Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in an internal review of a denial. The authorized representative may be the Plan Participant's treating Provider, if the Plan Participant appoints the Provider in writing.

Persons not involved in the previous decisions regarding the Plan Participant'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 and who is not subordinate to any previous decision-maker on the Plan Participant's Claim, will review Medical Necessity Appeals.

A Plan Participant must exhaust all internal Appeal opportunities prior to requesting an external Appeal conducted by an Independent Review Organization.

1. First level Internal Appeal

a. Administrative Appeal

The first level of an administrative Appeal is a process where the Claims Administrator reviews denials unrelated to medical Appeals. The Plan Participant, their authorized representative, including a Provider authorized to act on the Plan Participant's behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Plan Participant's receipt of an initial adverse Benefit determination. Requests submitted to the Claims Administrator after one hundred eighty (180) days of the denial will not be considered. For an Appeal based on rescission of coverage, the Plan Participant must file the Appeal within thirty (30) days of receipt of the notice of rescission.

The Claims Administrator will investigate the Plan Participant's concerns. When a medical opinion is needed for an administrative Appeal, a health care professional who was not previously involved in the initial decision, will be utilized. If the Claims Administrator changes the original decision at the Appeal level, the Claims Administrator will process the Plan Participant's Claim and notify the Plan Participant and all appropriate Providers, in writing, of the first level Appeal decision. If the Plan Participant's Claim is denied on Appeal, the Claims Administrator will notify the Plan Participant and all appropriate Providers, in writing, within thirty (30) calendar days of the Plan Participant's request, unless is the Claims Administrator mutually agrees that an extension of the time is warranted.

Administrative Appeals should be submitted in writing to:

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

b. Medical Appeals

If the Plan Participant is not satisfied with the Claims Administrator's denial of services involving a denial or partial denial based on Medical Necessity, appropriateness, health care setting, level of care, effectiveness or a determination that a service is experimental or Investigational, the Plan Participant or their authorized representative, including a Provider acting on their behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Plan Participant's receipt of an initial adverse Benefit determination. Medical Appeals should be submitted in writing to:

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

Requests submitted to the Claims Administrator after one hundred eighty (180) days of the denial will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. All Appeals of Medical Necessity denials will be reviewed by 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. If the initial denial is overturned on the Plan Participant's medical Appeal, the Claims Administrator will process the Claim and will notify the Plan Participant and all appropriate Providers, in writing, of the internal Appeal decision. If the initial denial is upheld, the Claims Administrator will notify the Plan Participant and all appropriate Providers, in writing, of the decision and advise the Plan Participant of their right to request an external Appeal. The decision will be mailed within thirty (30) days of the Plan Participant's request, unless the Plan Participant, their authorized representative and the Claims Administrator mutually agree that an extension of the time is warranted. At that time, the Claims Administrator will inform the Plan Participant of their right to begin the external Appeal process if the Claim meets the criteria.

2. Second Level Administrative Appeal

If the Claims Administrator does not reverse the decision, the Plan Participant may further Appeal the denial of Benefits to the Plan Administrator. Requests submitted after sixty (60) calendar days of the denial will not be considered. Send a written request for further review and any additional information to:

Insurance Advisory Committee
Louisiana Sheriffs' Association Group Benefits Program
1175 Nicholson Dr.
Baton Rouge, LA 70802

Requests submitted to the Claims Administrator will be forwarded to the Louisiana Sheriffs' Association Group Benefits Program. The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

- The Plan Participant must have completed the mandatory level of review prior to requesting a voluntary review.
- Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending.
- The Plan Participant's decision whether or not to submit to this voluntary level of review will have no effect on the Plan Participant's rights to any other Benefits under this Benefit Plan.
- The Plan Participant has the right to representation.
- The decision will be made by the Group or its designee.
- No fees or costs will be imposed on the Plan Participant to file a voluntary Appeal.

3. Second Level Medical / External Appeals

If the Plan Participant still disagrees with the determination on their Claim, the Plan Participant or their authorized representative may request an external Appeal conducted by a non-affiliated Independent Review Organization (IRO). The Plan Participant must send their written request for an external Appeal, within one hundred twenty (120) days of receipt of the internal Appeal decision, to:

Insurance Advisory Committee
Louisiana Sheriffs' Association Group Benefits Program
1175 Nicholson Dr.
Baton Rouge, LA 70802

Requests submitted to the Plan Administrator after one hundred twenty (120) days of receipt of the internal Appeal decision will not be considered.

The Plan Participant's request must be accompanied by a fee of twenty-five dollars ($25.00) made payable to Louisiana Sheriffs' Association Group Benefits Program, 1175 Nicolson Drive, Baton Rouge, LA 70802.

The Claims Administrator will provide all pertinent information necessary to conduct the Appeal. The IRO decision will be considered a final and binding decision on both the Plan Participant and the Claims Administrator. The external review will be completed within forty-five (45) days of receipt of the request and the IRO will notify the Plan Participant or their authorized representative and all appropriate Providers of its decision.

4. Expedited Appeals

a. Expedited Internal Appeals

The Claims Administrator provides an Expedited Appeal process for review of an adverse determination involving a situation where the time frame of the standard Appeal would seriously jeopardize the Plan Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard internal Appeal decision. In these cases, the Claims Administrator will make a decision no later than seventy-two (72) hours of our receipt of an Expedited Appeal request that meets the criteria for Expedited Appeal.

An Expedited Appeal is a request concerning an Admission, availability of care, continued stay, or health care service for a Plan Participant 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 Plan Participant; the Plan Participant's authorized representative, or the Provider acting on behalf of the Plan Participant. Requests for an expedited internal Appeal may be oral or written and should be made to:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022
1-800-392-4086 or 1-225-291-5370

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

b. Expedited External Appeal

An Expedited External Appeal is a request for immediate review, by an Independent Review Organization (IRO), of an initial adverse determination not to Authorize continued services for covered persons currently in the emergency room, under observation in a facility or receiving inpatient care.

Expedited External Appeals are not provided for review of services previously rendered. An Expedited External Appeal of an adverse decision is available if the Plan Participant's life, health or ability to regain maximum function is in serious jeopardy; or when in the opinion of the treating physician, the covered person may experience pain that cannot be adequately controlled while waiting for a decision on a second level external Appeal. All pertinent information for Expedited External Appeal requests will be provided so the review may be completed within seventy-two (72) hours of receipt.

5. Binding Nature of External Appeal Decisions

All external review decisions are binding on the Plan and the covered person for purposes of determining coverage under this Benefit Plan that involve a determination of Medical Necessity or whether a medical service is Investigational. This Appeals process shall constitute the Plan Participant's sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary or Investigational, except to the extent that other remedies are available under State or Federal law.

ARTICLE XXII. GENERAL PLAN INFORMATION

NAME OF PLAN: Louisiana Sheriffs' Association Group Benefits Program

NAME AND ADDRESS OF EMPLOYER/PLAN SPONSOR: Louisiana Sheriffs' Association Group Benefits Program
1175 Nicolson Drive
Baton Rouge, LA 70802
1-225-343-8402

EMPLOYER IDENTIFICATION NUMBER (EIN): 37-6485374

PLAN NUMBER (PN): 501(C)(9)

TYPE OF PLAN: Group Major Medical Benefit Plan

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

PLAN ADMINISTRATOR: Louisiana Sheriffs' Association Group Benefits Program
1175 Nicolson Drive
Baton Rouge, LA 70802
1-225-343-8402

AGENT FOR SERVICE OF LEGAL PROCESS: Usry, Weeks and Matthews, APLC
1615 Poydras Street, Suite 1250
New Orleans, LA 70112
1-504-592-4600

Service for legal process may be made upon the Plan Administrator or if applicable, a Plan Trustee.

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

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

PLAN YEAR ENDS: (June 30th)

PLAN DETAILS: The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any Benefits are described in the Benefit Plan.

FUTURE OF THE PLAN: Although the Plan Sponsor expects and intends to continue the Benefit Plan indefinitely, the Group reserves the right to modify, amend, suspend, or terminate the Benefit Plan at any time.