

**HMO POINT OF SERVICE  
BENEFIT PLAN  
FOR**



**GROUP BENEFIT PROGRAM**

Administered by



A subsidiary of Blue Cross and Blue Shield of Louisiana,  
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**SCHEDULE OF BENEFITS  
HMO POINT OF SERVICE  
CONTRACT 131HR 01237 0111**

**GROUP NAME**

East Baton Rouge Parish School System (EBRPSS)

**GROUP NUMBER**

77749 and Departments (Buy Up Plan)

**GROUP'S ORIGINAL CONTRACT DATE**

January 1, 2006

**GROUP'S ANNIVERSARY DATE**

January 1<sup>st</sup>

**GROUP'S AMENDED CONTRACT DATE**

January 1, 2011

**SCHEDULE OF BENEFITS**

Benefit Period	Calendar Year for all providers

**COPAYMENTS AND COINSURANCE**

	<b>NETWORK</b>	<b>NON-NETWORK</b>	<b>DEPENDENT OUT-OF-AREA</b>
	Coinsurance shown as Group - Member responsibility Copayments shown are the Member's responsibility		
Outpatient visits for the following services:	\$25.00 per visit	65%-35%	\$25.00 per visit
<ul style="list-style-type: none"> <li>• Primary Care Physician's office visits for the following Physician and/or Provider specialties:               <ul style="list-style-type: none"> <li>• General Practice</li> <li>• Family Practice</li> <li>• Pediatrics</li> <li>• Internal Medicine</li> <li>• OB/GYN</li> <li>• Licensed Professional Counselor</li> <li>• Masters of Social Work</li> <li>• Physiotherapists</li> <li>• Psychiatrists</li> <li>• Psychologist</li> <li>• Substance Abuse Counselor</li> </ul> </li> </ul>			

<ul style="list-style-type: none"> <li>Speech Therapy, Physical Therapy, Occupational Therapy, Cardiac Rehabilitation</li> </ul>	85%-15%	65%-35%	85%-15%
<ul style="list-style-type: none"> <li>Preventive and Wellness Care</li> </ul>	100% - 0%	100% - 0% Deductible is not applicable	100% - 0%
Outpatient visits for Specialists and Allied Health Professionals office visits for providers not included above	\$50.00 per visit	65%-35%	\$50.00 per visit
Vision Care Exam, limited to 1 exam in a 24 month period (Optometrist only).	\$30.00 per visit	\$30.00 per visit	\$30.00 per Visit
Emergency Medical Services performed in the Emergency Department of a Hospital	85%-15%	85%-15%	85%-15%
Chiropractic Services	\$50.00 per visit	65%-35% after Deductible 20 visits each Benefit Period	\$50.00 per visit
Ambulance Services	85%-15%	65%-35%	85%-15%
Ambulatory Surgical Facility and Outpatient Surgical Facility	\$50.00 per surgical visit then 85%-15%	65%-35%	\$50.00 per surgical visit then 85%-15%
Inpatient Hospital Admission, all Inpatient Hospital services included  (Copayment is in addition to the Deductible Amount and the Deductible Amount is not reduced by the Copayment.)	\$400.00 per Admission then 85%-15%	65%-35%	\$400.00 per Admission then 85%-15%
Physician's services for Pregnancy Care	\$25.00 per pregnancy	65%-35%	\$25.00 per pregnancy
Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices	80% - 20%	65%-35%	80% - 20%

Inpatient and Outpatient services for which a Copayment is not applicable	85%-15%	65%-35%	85%-15%
Services for: <ul style="list-style-type: none"> <li>Home Health Care, (limited to 75 visits each Benefit Period)</li> <li>Hospice Care, (limited to 180 days Lifetime Maximum)</li> <li>Skilled Nursing Facility, (limited to 60 days each Benefit Period)</li> </ul>	85%-15%	65%-35%	85%-15%
Contraceptive devices and contraceptive drugs (such as IUD, diaphragms, Depo Provera, Lunelle, Implanon implant) are covered when administered in a Physician's office.	85%-15%	65%-35%	85%-15%
All other services	85%-15%	65%-35%	85%-15%

## MENTAL DISORDERS, ALCOHOL AND/OR DRUG ABUSE

### NETWORK, NON-NETWORK AND DEPENDENT OUT-OF-AREA SERVICES

**Coinsurance and Inpatient Hospital Copayments for Mental Disorders, Alcohol and/or Drug Abuse are the same as for any other illness**

- The Member's Coinsurance for Mental Disorders, Alcohol and/or Drug Abuse **is eligible** for satisfying the Out-of-Pocket Amount.

	NETWORK	NON-NETWORK	DEPENDENT OUT-OF-AREA
Copayment or Coinsurance for Physician's office visit for Mental Disorders, Alcohol and/or Drug Abuse	\$25.00 per visit; then 100% - 0%	65%-35%	\$25.00 per visit; then 100% - 0%

### INPATIENT SERVICES

### MAXIMUM

Mental Disorders, Alcohol and/or Drug Abuse

Benefits are payable same as any other illness

### OUTPATIENT SERVICES

### MAXIMUM

Mental Disorders, Alcohol and/or Drug Abuse

Benefits are payable same as any other illness

## DEDUCTIBLE/OUT-OF-POCKET AMOUNT

	NETWORK	NON-NETWORK	DEPENDENT OUT-OF-AREA
<b>Benefit Period Deductible Amount</b>	\$400.00	\$1,200.00	\$400.00
The Deductible Amount incurred for each Provider <b>is not</b> eligible for satisfying the Deductible amount for the other Provider.			
<b>Out-Of-Pocket Amount</b>	\$2,500.00	\$7,500.00	\$2,500.00
Remaining Coinsurance incurred for Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices provided by a Non-Network Provider is not eligible for satisfying the Out-Of-Pocket Amount.			
The Out-Of-Pocket Amount incurred for each Provider <b>is not</b> eligible for satisfying the Out-Of-Pocket Amount for the other Provider.			
<b>Family Out-Of-Pocket Amount [Aggregate]</b>	\$5,000.00	\$15,000.00	\$5,000.00
The Out-Of-Pocket Amount incurred for each Provider <b>is not</b> eligible for satisfying the Out-Of-Pocket Amount for the other Provider.			

## ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

- Benefits are subject to applicable Deductible, Coinsurance, Inpatient and Outpatient Copayments.
- Organ, tissue and bone marrow transplants and evaluation for a Member's suitability for organ, tissue and bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered.
- Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

	NETWORK	DEPENDENT OUT-OF-AREA
Organ, Tissue Bone Marrow Transplant Maximum	Same as for any other illness	Same as for any other illness
Acquisition Expense Maximum	Same as for any other illness	Same as for any other illness

## PRIVATE DUTY NURSING

Outpatient Private Duty Nursing services are limited to a Benefit Period maximum of \$5,000.00 for each member.

## DIETICIAN VISITS

Benefits are limited to a maximum of \$250.00 in Allowable Charges per Benefit Period for each Member.

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## AUTHORIZATION OF ADMISSIONS

- **We must Authorize all Inpatient Admissions prior to the Admission. If Authorization of the Inpatient Admission is not obtained, the Member's claim may be reviewed for Medical Necessity. If We determine that the Admission was not Medically Necessary, the Admission will not be covered.**
- **If a Network Provider fails to obtain Authorization prior to the Admission and We make the determination that the Admission was Medically Necessary, We will reduce Our payment to that Provider by [\$0 - 2,000.00]**
- **If the Member is admitted to a Non-Network facility without Our prior approval for care at that facility, We will review the claim for Medical Necessity. If it was Medically Necessary, the Member must pay his Non-Network Deductible Amount and the Coinsurance percentage, and may have to pay up to the facility's billed charge. Any Claim that We determine was not Medically Necessary will be denied and the Member may have to pay the facility's billed charges.**
- **Requests for Authorization of all Admissions and for Concurrent Review of an Admission in progress must be made to HMO Louisiana, Inc. by calling 1-800-376-7973.**
- **If a request for Authorization or Concurrent Review is denied, the Admission will not be covered.**

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## AUTHORIZATION FOR OUTPATIENT SERVICES AND SUPPLIES

Authorization must be obtained prior to the listed Outpatient services or supplies being rendered.

If Authorization is not requested prior to a listed service or supply being rendered, We have the right to determine if the service or supply is Medically Necessary. If it was Medically Necessary, Benefits will be provided based on the Network status of the Provider of the service or supply. If a Network Provider fails to obtain a required Outpatient service and supply Authorization, We will reduce Our payment to the Network Provider by thirty percent (30%) of the Allowable Charge and the Provider is responsible for all non-covered charges. The Member remains responsible for his applicable Network Copayment, Deductible amount and Coinsurance percentage. If a service or supply was not Medically Necessary, the service or supply is not covered and no Benefits will be paid.

If the Member receives services and supplies from a Non-Network Provider, the Member is responsible for ensuring that the Provider contacts Us and obtains Authorization prior to receiving the listed services. Members receiving care from a Non-Network Provider without Our prior approval of that Provider will receive reduced payment toward their services as claims will be adjudicated at the Non-Network level of Benefits shown on the Schedule of Benefits. The Member will be responsible for all charges up to the Provider's billed charge, in addition to his Deductible and/or Coinsurance amounts.

- **Requests for Authorization must be made to HMO Louisiana, Inc. by calling 1-800-376-7973.**
- Refer to the "Authorization of Services" section in this Contract for complete information.
  - Bone growth stimulator
  - Cardiac Rehabilitation
  - CT Scans
  - Durable Medical Equipment (greater than \$200.00)
  - Home Health Care
  - Hospice Care
  - Implantable Medical Devices over \$2000.00 such as Implantable Defibrillator and Insulin Pump

- Intensive Outpatient Programs
  - M.R.I./M.R.A.
  - Non-Emergency Ambulance
  - Nuclear Cardiology
  - Occupational Therapy
  - Orthotic Devices
  - Outpatient surgical procedures not performed in a Physician's office
  - Partial Hospitalization Programs
  - PET/SPECT Scans
  - Physical Therapy
  - Private Duty Nursing
  - Prosthetic Appliances (greater than \$500.00)
  - Residential Treatment Centers
  - Speech Therapy
  - Sleep Studies
  - Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
  - Vacuum Assisted Wound Closure Therapy
  - Medical Nutritional Education/Therapy for Diabetes
  - Skilled Nursing Facility Services
  - Applied Behavior Analysis
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**EAST BATON ROUGE PARISH SCHOOL SYSTEM (EBRPSS)  
HMO LOUISIANA, INC. POINT OF SERVICE  
ASO BENEFIT PLAN  
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## INTRODUCTION TO BENEFITS AND PROVIDER NETWORK

HMO Louisiana, Inc. issues this health Benefit Plan to the employer Group. The Group is the policyholder shown on the Schedule of Benefits. A copy of this Benefit Plan provided to Subscribers serves as the Subscriber's certificate of coverage. As of the Benefit Plan Date or Amended Benefit Plan Date shown on the Group's Schedule of Benefits, the Group agrees to provide the Benefits specified herein for Subscribers of the Group and their enrolled Dependents.

This Benefit Plan replaces any others previously issued to the Group/Policyholder, as of the Amended Benefit Plan Date. This Benefit Plan describes Member Benefits, as well as Member rights and responsibilities under the Benefit Plan. We encourage You, the Member, to read this Benefit Plan carefully.

Many of the sections of this Benefit Plan are related to other sections of this Benefit Plan. You may not have all of the information You need by reading just one section.

**The Group is the Plan Sponsor of this Benefit Plan. HMO Louisiana, Inc. is the Claim Administrator and provides administrative Claims payment services only and does not assume any financial risk or obligation with respect to Claims liability.**

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

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.

### FACTS ABOUT THIS HMO POINT OF SERVICE BENEFIT PLAN

This is a Point of Service Benefit Plan. Members have an extensive network of Providers (Network) available to them - the HMOLA Network. Members can get care from Providers in their Network, or from Providers who are not in their Network.

Members who get care from Providers in their Network will pay the least for their care and get the most value from this policy. Members usually pay a Copayment to a Network Provider at the time of service.

Members can go outside the Network and obtain care from Providers that are not in the HMOLA Network. Members usually pay a Deductible and Coinsurance when they receive care from Providers outside the Network. Participating Providers are those Providers that have signed contracts to participate in the networks of Blue Cross and Blue Shield of Louisiana or another Blue Cross and Blue Shield Plan. Non-Participating Providers are Providers that do not have a contract to participate in the HMOLA Network or any Blue Cross and Blue Shield network. A Non-Participating Hospital penalty may apply when Members receive care from a Non-Participating Hospital – a Hospital that is not in the HMOLA Network or a network of a Blue Cross and Blue Shield plan.

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

This is a direct access plan. Members may see Specialists in the HMOLA Network without contacting a Primary Care Physician or obtaining a referral from a Primary Care Physician.

### OUR HMOLA PROVIDER NETWORK

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

We use the term “Network Benefits” to mean the highest level of Benefits payable under this Benefit plan when the Member uses Providers in the HMOLA Network. We use the term “Non-Network Benefits” to mean a lower level of Benefit, if a Member chooses to go outside the HMOLA Network for care.

To receive Network Benefits, the Member should always verify that a Provider is a current HMOLA Network Provider. Members may review a current paper Provider directory, check on-line at [www.bcbsla.com](http://www.bcbsla.com), or contact Our Customer Service Department at the number listed on their I.D. card. Our Network may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas.

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

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

The Group pays a lower level of Benefits when a Member uses a Provider outside the HMOLA Network. Benefits may also be based on a lower Allowable Charge and/or the application of a penalty. The Member will usually pay Deductible and Coinsurance instead of a Copayment. Receiving care from a Non-Network Provider will result in higher out-of-pocket costs to the Member. Because Non-Network Providers are able to balance bill Members up to their full billed charge, out-of-pocket costs could be significant. These amounts do not apply to the Out-of-Pocket Maximum. We recommend that You ask the non-network physician or health care professional about their billed charges before You receive care.

### **SELECTING AND USING A PRIMARY CARE PHYSICIAN**

This direct access plan allows You to receive care from a Primary Care Physician (“PCP”) or from a Specialist Physician. No PCP referral is required prior to accessing care directly from a Specialist in the HMOLA Network.

Members pay the lowest Physician Copayment when obtaining care from a PCP. PCPs are Family Practitioners, General Practitioners, Internists and Pediatricians. Each Member of the family may use a different PCP. PCPs will coordinate health care needs from Consultation to Hospitalization, will direct a Member to an appropriate Provider when necessary, and will assist in obtaining any required Authorizations.

If one Provider directs a Member to another Provider, the Member must make sure that the new Provider is in the HMOLA Network before receiving care. If the new Provider is not in the HMOLA Network, Benefits will be processed at the Non-Network Benefit level and the Allowable Charge applicable to that Provider.

### **AUTHORIZATIONS**

Some services and supplies require Authorization from Us before the services are obtained. Your Schedule of Benefits lists the services and supplies that require this advance Authorization.

An Authorization is Our determination that it is Medically Necessary for the Member to receive the requested medical services. When We Authorize a service for Medical Necessity, We are not making a determination about the Member’s choice of Provider or the level of Benefits that will apply to a resulting Claim.

Network Providers are required to obtain necessary Authorizations on behalf of the Member. When a Network Provider fails to obtain a required Authorization, We penalize the Network Provider, not the Member, as described in the Schedule of Benefits. The Member continues to be responsible only for the applicable Network Copayment, Deductible, and/or Coinsurance shown in the Schedule of Benefits.

When We issue an Authorization but the Member receives the service from a Non-HMOLA Provider, (a Participating or Non-Participating Provider), Non-Network Benefits will apply, even when We have Authorized the services as Medically Necessary. A Member must obtain care from a Provider in the HMOLA Network to receive the highest level of Benefits available under this Benefit Plan.

No payment will be made for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless We Authorize these services and the services are rendered by a Blue Distinction Center for Transplants or a transplant facility in Our HMOLA Network, unless otherwise approved by Us in writing. To locate an approved transplant facility, contact Our Customer Service Department at the number listed on Your ID card.

### **REQUIRED NOTICES:**

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT [www.bcbsla.com](http://www.bcbsla.com) OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON THE BACK OF YOUR I.D. CARD.

THE MEMBER'S SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN THE MEMBER'S HEALTH PLAN AND THE MEMBER'S PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW THE MEMBER'S PROVIDER TO BILL THE MEMBER FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

WE BASE THE GROUP'S PAYMENT OF BENEFITS FOR THE MEMBER'S COVERED SERVICES ON AN AMOUNT KNOWN AS THE ALLOWABLE CHARGE. THE ALLOWABLE CHARGE DEPENDS ON THE SPECIFIC PROVIDER FROM WHOM A MEMBER RECEIVES COVERED SERVICES, AS SEEN IN THE EXAMPLE BELOW.

### **HOW WE DETERMINE WHAT THE GROUP PAYS FOR THE MEMBER'S COVERED SERVICES**

*(Please see next section for information regarding Dependent Out-of-Area Benefits)*

#### **What the Group pays when a Member uses Network Providers**

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

#### **What the Group pays when a Member uses Participating Providers**

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

## **What the Groups pays when a Member uses Non-Participating Providers**

Non-Participating Providers do not have a contract for the HMOLA Network, with Blue Cross and Blue Shield of Louisiana, or any another Blue Cross and Blue Shield plan. These Providers are not in Our Networks. We have no fee arrangements with them. We establish an Allowable Charge for Covered Services rendered by Non-Participating Providers. We use the lesser of the Provider's actual billed charge or the established Allowable Charge to determine what to pay for a Member's Covered Services when the Member receives care from a Non-Participating Provider. The Member will receive a lower level of Benefit because he did not receive care from a Network Provider.

Member has a right to file an Appeal with the Company for consideration of a higher level of Benefits if the Member received Covered Services from a Nonparticipating Provider who was the only Provider available to deliver the Covered Service within a seventy-five (75) mile radius of the Member's home. If the Member received a covered Emergency Medical Service from a Non-Participating Hospital, and the non-network level of Benefits was applied, the Member may appeal for consideration of a higher level of Benefits. To file an Appeal, the Member must follow the Appeal procedures set forth in this Benefit Plan.

Members usually pay significant costs when using Non-Participating Providers. This is because the amounts that Providers charge for Covered Service are usually higher than the fees that are accepted by HMOLA and Participating Providers. Also, HMOLA and Participating Providers waive the difference between the actual billed charge for Covered Services and the Allowable Charge, while Non-Participating Providers do not. The Member will pay the amounts shown in the "Non-Network" column on their Schedule of Benefits, and the Provider may balance bill the Member for all amounts not paid by HMO Louisiana, Inc.

### **SAMPLE ILLUSTRATION OF MEMBER COSTS WHEN USING A NON-PARTICIPATING HOSPITAL**

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

Example: A Member has this Point of Service plan with a \$150 Hospital Copayment. The Non-Network Benefits are 60% - 40% Coinsurance with a Deductible. Assume the Member goes to the Hospital, has previously met his Deductible and has obtained the necessary Authorization prior to receiving a non-emergency service. The Provider's billed charge for the Covered Service is \$12,000. We negotiated an Allowable Charge of \$2,500 with HMOLA Network Providers 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 Provider Hospital.**

<b>The Member receives Covered Services from:</b>	<b>HMOLA Provider Hospital</b>	<b>Participating Provider Hospital</b>	<b>Non-Participating Provider Hospital</b>
Provider's Bill:	\$12,000	\$12,000	\$12,000
Allowable Charge:	\$2,500	\$3,000	\$2,500
<b>Group pays:</b>	<b>\$2,350</b> \$2,500 allowable -\$150 copayment = \$2,350	<b>\$1,800</b> \$3,000 allowable charge x 60% Coinsurance = \$1,800	<b>\$1,500</b> \$2,500 allowable charge x 60% Coinsurance = \$1,500
<b>Member pays:</b>	<b>\$150</b> Copayment	<b>\$1,200</b> 40% Coinsurance x \$3,000 allowable charge = \$1,200	<b>\$1,000</b> \$2,500 allowable charge x 40% Coinsurance = \$1,000
Is Member billed up to the Provider's billed charge?	NO	NO	YES - \$9,500, for a total of:
<b>TOTAL MEMBER PAYS:</b>	<b>\$150</b>	<b>\$1,200</b>	<b>\$10,500</b>

### **DEPENDENT OUT-OF-AREA BENEFITS**

The Subscriber's Dependent who is regularly located outside of the Subscriber's defined Service Area may apply to HMO Louisiana, Inc. to be set up as a Dependent Out-of-Area, and receive Dependent Out-of-Area Benefits under this Benefit Plan. A Dependent who has elected Dependent Out-of-Area Benefits may receive care from a HMOLA Network Provider in any of the service areas in this state, may receive care from a Participating Provider or may receive care from a Non-Participating Provider.

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

### **SAMPLE ILLUSTRATION OF DEPENDENT OUT-OF-AREA MEMBER COSTS WHEN USING A NON-PARTICIPATING HOSPITAL**

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

A Member is enrolled in Dependent Out-of-Area Benefits. The Dependent Out-of-Area Benefits are 80% - 20% Coinsurance with a Deductible. Assume the Member has met his Deductible. The billed charge for the Covered Hospital Service that the Member receives is \$12,000. We have negotiated an Allowable Charge of \$2,500 with HMOLA Network Providers for this service. There is a negotiated Allowable Charge of \$3,000 with Participating Providers for this service. Because there is no agreement with Non-Participating Providers, We established an Allowable Charge of \$2,500 for this service when rendered by Non-Participating Provider Hospitals.

<b>The Member receives Covered Services from:</b>	<b>HMOLA Provider</b>	<b>Participating Provider</b>	<b>Non-Participating Provider Hospital</b>
Provider's Bill:	\$12,000	\$12,000	\$12,000
Allowable Charge:	\$2,500	\$3,000	\$2,500
<b>Group pays:</b>	<b>\$2,000</b> \$2,500 Allowable Charge x 80% Coinsurance = \$2,000	<b>\$2,400</b> \$3,000 Allowable Charge x 80% Coinsurance = \$2,400	<b>\$2,000</b> \$2,500 Allowable Charge x 80% Coinsurance = \$2,000
<b>Member pays:</b>	<b>\$500</b> 20% Coinsurance x \$2,500 Allowable Charge = \$500	<b>\$600</b> 20% Coinsurance x \$3,000 Allowable Charge = \$600	<b>\$500</b> 20% Coinsurance x \$2,500 Allowable Charge = \$500
Is Member billed up to the Provider's billed charge?	NO	NO	YES - \$9,500, for a total of:
<b>TOTAL MEMBER PAYS:</b>	<b>\$500</b>	<b>\$600</b>	<b>\$10,000</b>

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

### **MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE BENEFITS**

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

### **ASSIGNMENT**

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

## **MEMBER INCENTIVES**

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

## **CUSTOMER SERVICE**

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

## ARTICLE I.

## DEFINITIONS

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

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

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

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

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

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

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

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

Ambulatory Surgical Center - An 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 the Member or his authorized representative to change a previous decision that We made. Examples of issues that qualify as appeals include denied Authorizations or Claims based on adverse determinations of Medical Necessity or Benefit determinations.

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

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

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

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

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

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

Benefit Plan - This program established by the Group to provide Benefits for eligible Members.

Benefit Plan Date - The date upon which the Group agrees to begin providing Benefits for Covered Services to Members 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.

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

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

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

Claim Administrator - The entity with whom the Group (Plan Sponsor) has contracted to handle the Claims payment functions of its Plan. For purposes of this Plan, the Claims Administrator is HMO Louisiana, Inc.

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

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

Complaint - An oral expression of dissatisfaction with Us or with Provider services.

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

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

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

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

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

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

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

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

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

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

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

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

#### Deductible Amounts

##### A. Benefit Period Deductible Amount

1. "Benefit Period Deductible Amount" - The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Member must pay within a Benefit Period when receiving Network, Non-Network and Dependent Out-of-Area Benefits, before Benefits are provided.
  2. Network, Non-Network and Dependent Out-of-Area benefit categories each carry a separate Benefit Period Deductible Amount as shown in the Schedule of Benefits. Any amounts accruing to the Member's Deductible Amount under one category of Benefits will accrue to the required Deductible Amount for all other categories of Benefits to which a Deductible Amount applies.
- B. Family Deductible Amount, if shown in the Schedule of Benefits, is the amount shown in the Schedule of Benefits for each category of Benefits to which a Deductible applies. Once a family has met its Family Deductible, this Benefit Plan starts paying Benefits for all members of the family, regardless of whether each individual has met his individual amount. Family Deductibles may apply to other types of Deductibles described in this Benefit Plan.

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

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

Dependent –

- A. the covered Employee's legal spouse; and/or
- B. any Children from date of birth to twenty-six (26) years of age, or
- C. any Children who are mentally or physically disabled and incapable of self-support prior to reaching ag 26 and who are dependent on the Employee for support, for as long as the disability continues. **Note: For purposes of this section, mental illness does not constitute mental retardation.** The Company must receive satisfactory proof of the disability from a licensed medical doctor as often as it deems necessary.
- D. any Dependent parent (only if enrolled prior to July 1, 1984) of an Employee or of an Employee's legal spouse, if living in the same household and if fully dependent upon the Employee or upon the Employee's legal spouse and who has resided with the covered Employee for the period of twelve (12) consecutive months immediately prior to the date of such enrollment.

The term "Children" as used herein shall mean (health and accident only):

- (1) Any natural or legally adopted Children of the Employee and/or the Employee's legal spouse;
- (2) Any Children in the process of being adopted by the covered Employee through an adoption agency or through a private adoption who are living in the household of the Employee;
- (3) Such other Children for whom the Employee has legal custody;
- (4) Grandchildren (covered prior to July 1, 1991) dependent upon the Employee for support, living in the household of the Employee; or

- (5) Grandchildren (covered July 1, 1991 or after) not in the legal custody of the Employee, but who are dependent upon the Employee for support and living in the household of the Employee. Such grandchildren must have a parent currently covered as a Dependent of the Employee. If the Employee seeking to cover the grandchild is the paternal grandparent, the Company will require that the biological father (i.e., the covered son of the Employee) execute an acknowledgment of paternity in accordance with Louisiana law. **Note:** If the Dependent parent becomes ineligible, the grandchild no longer meets this definition and is also ineligible.

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

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

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

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

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

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

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

Emergency - See “Emergency Medical Condition.”

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

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

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

Employee - A full-time, active employee of the Group. An Employee is considered to be full-time if he normally works at least thirty (30) hours per week and is on the regular payroll of the Group for that work.

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

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

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

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

Group - East Baton Rouge Parish School System (EBRPSS) who is the plan sponsor of this Benefit Plan and for whom HMO Louisiana, Inc. provides Claims administration services.

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

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

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

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

Independent Review Organization (IRO) - An Independent Review Organization, not affiliated with Us, that conducts external reviews of final adverse determinations. The decision of the IRO is binding on both the insured and the Company.

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

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

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

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

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

will be based on a consideration of the following:

- A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
  1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);
  2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
  3. reference to federal regulations.

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

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

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

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

Member - A Subscriber or an enrolled Dependent.

Mental Disorder - A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychoses, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by Louisiana state law at L.R.S. 22:1043 (formerly 22:669) (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under seventeen (17) years of age; Rett’s Disorder; and Tourette’s Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic Mental Disorders, to be determined by the Company. The definition of Mental Disorder shall be the basis for determining benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Network Benefits - Benefits for care received from a Network Provider or for care received from a Non-Network Provider that We have Authorized where required.

Network Provider - A Provider that has signed an agreement with Us to participate as a member of the **HMO Louisiana, Inc.** Provider Network.

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

Non-Network Benefits – Benefits for care received from Non-Network Providers that We have not Authorized and for care that have not been Authorized by Us where required.

Non-Network Provider - A Provider who is not a member of the **HMO Louisiana, Inc.** Network.

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

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

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

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

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

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

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

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

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

Pre-Existing Condition - With respect to late applicants, any disease, illness, accident or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) month period immediately prior to the Effective Date of coverage. The term "Pre-Existing Condition" will also include any condition which is related to any such illness, accident, injury, or disease.

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

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

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

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

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

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

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

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

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

- A. HMOLA Provider - A Provider that has a signed contract with Us to participate in Our Provider Network.
- B. Participating Provider - A Provider that does not have a signed contract with Us, but has a signed contract with Our parent company, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan to participate in its Provider networks.
- C. Non-Participating Provider - A Provider that does not have a signed contract with Us, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan pertaining to payment for Covered Services rendered to a Member.

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

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

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

Retiree – An Employee who was covered by the parish school board's health and accident insurance contract immediately prior to the date of retirement; and

- A. who, upon retirement, immediately received retirement benefits from an approved state or state governmental agency retirement plan; or

- B. who was not eligible for participation in such a plan or who had legally opted not to participate in such a plan, and
1. was employed prior to September 16, 1979, has ten (10) years of continuous service and has reached the age of sixty-five (65); or
  2. if employed after September 16, 1979, has ten (10) years of state service and has reached the age of seventy (70); or
  3. was employed after July 8, 1992, has ten (10) years of continuous state service, had a credit for at least forty (40) quarters in the Social Security system at the time of employment, and has reached the age of sixty-five (65); or
  4. maintained continuous coverage with the employer as an eligible Dependent until he became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan; or
- C. who, upon retirement, immediately received retirement benefits from a state approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan shall be responsible for certification of eligibility hereunder to the Company.
- D. Retiree also means an individual who was a covered Employee who continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any items A., B., or C. above.

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

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

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

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

**Special Care Unit** - A designated Hospital unit which We approve and which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, such as an intermediate care neonatal unit, telemetry unit for heart patients, or an isolation unit.

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

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

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

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

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

Surgery -

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

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

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

Transplant Acquisition Expense Maximum - The maximum amount the Group will pay under this Benefit Plan for a donor's medical expenses, for each transplant covered under this Benefit Plan. Non-medical expenses, such as living expenses, are non-Covered expenses. The Transplant Acquisition Expense Maximum will accrue to any Organ, Tissue and Bone Marrow Transplant Lifetime Maximum shown in the Schedule of Benefits, regardless of when the expenses are incurred.

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

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

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

Waiting Period - see "Eligibility Waiting Period."

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

## ARTICLE II.

## SCHEDULE OF ELIGIBILITY

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

### A. Employees

1. An eligible Employee is a person meeting the definition of "Employee" as contained in the Benefit Plan. However, a person covered as a Retiree under the Office of Group Benefits is not eligible for coverage as an Employee under the Benefit Plan.
2. Husband and wife, both Employees.

In no event may a person be enrolled simultaneously as an Employee and as a Dependent under the Benefit Plan, **nor may a Dependent be covered by more than one Employee.** If a covered spouse chooses at a later date to be covered separately, and is eligible for coverage as an Employee, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase the benefits.

3. Re-enrollment; Previous Employment

An Employee whose employment is terminated while covered or eligible for coverage under the Benefit Plan is eligible for reenrollment on the date of reemployment if he is reemployed within twelve (12) months of the Effective Date of termination. The Employee will be eligible only for that Class of Coverage in force on the date of termination. Coverage upon reenrollment will be subject to all modifications of eligible expenses, Benefits, and/or premiums, which became effective in the interim. If an Employee acquires an additional Dependent during the period of termination, that Dependent may be covered if added within thirty (30) days of re-employment.

4. Members of Boards and Commissions

Except as otherwise provided by law, members of boards or commissions are not eligible for participation in the Benefit Plan. This section does not apply to members of school boards or members of state boards or commissions who are defined by the Group as full-time Employees.

5. Pre-Existing Conditions – New Employees

- (a) Applicants may be required to complete a health questionnaire.
- (b) New Employees (and their eligible Dependents) who apply for coverage with the Group within thirty (30) days of becoming eligible to participate in the Group's health care plan are not subject to a Pre-Existing Condition Waiting Period. New Employees (and their eligible Dependents age 19 and older) who do not apply for coverage with the Group within thirty (30) days of becoming eligible to participate in the Group's health care plan are subject to the twelve (12) month Pre-Existing Condition Exclusion Waiting Period as described in the Benefit Plan. Eligible Dependents under age 19 are never subject to a Pre-Existing Condition Exclusion Waiting Period.

New Employees (and their eligible Dependents) will be subject to all other conditions and provisions set forth in the Benefit Plan.

- (c) If the Employee or Dependent was previously covered under a group health plan, health insurance coverage, Part A or Part B of Title XVII of the Social Security Act (Medicare), Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under Section 1928 thereof, or State Children's Health Insurance Program ("CHIP") or other Creditable Coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and the rules and regulations promulgated pursuant thereto, the duration of the prior

coverage will be credited against any applicable Pre-Existing Condition Exclusion Waiting Period as long as the prior coverage did not end more than sixty-three (63) days before the date of enrollment for coverage in this Benefit Plan.

## **B. Retirees**

A person meeting the definition of "Retiree" shall be eligible for coverage under this Benefit Plan. However, a person who retired from one Group may be covered as an Employee under another Group or as a Retiree of the Group from which he retired, but not both. In order to retain eligibility as a Retiree, the person must apply for coverage as a Retiree within thirty (30) days of termination of employment with the employer participating in the Office of Group Benefits. A Retiree not applying for coverage within thirty (30) days after this date of retirement or during the above period of eligibility will not be eligible for coverage. **The Retiree will be responsible for notifying his initial Group of re-employment, and/or return to Retiree status.**

Retired participants of the EBRPSS medical plans and their covered dependent spouses, who reach age sixty-five (65) on or after June 1, 2005, must enroll in Medicare Parts A and B in order for their claims to be paid under this Plan. If a retired participant or covered spouse are eligible for Medicare, but do not enroll for Parts A and B, the claims of the person eligible for Medicare will be denied.

Medicare pays primary coverage for those retired participants and their covered dependent spouses who are enrolled in Parts A and B. The EBRPSS medical plan will pay secondary to Medicare for such persons. The retired participant's claim cannot be processed until the EBRPSS medical plan claims administrator receives an explanation of benefits from Medicare indicating what Medicare paid as primary coverage.

The above provisions do not apply to a covered dependent spouse under age sixty-five (65) or the dependent eligible retired participants who are under age sixty-five (65) and their covered dependents. Coverage for such persons will continue to be provided as primary under the EBRPSS medical plans.

Retired participants not entitled to Medicare Parts A and B must supply EBRPSS the appropriate documentation from the Social Security Administration evidencing denial of entitlement. The EBRPSS medical plan in force will continue to provide primary coverage for retired participants who are not entitled to Medicare.

## **C. Dependents**

1. A Dependent, as defined in the Benefit Plan, of an eligible Employee or Retiree shall be eligible for Dependent coverage on the later of the following dates:
  - a. The date the Employee or Retiree becomes eligible for Benefits under the Benefit Plan.
  - b. The date the covered Employee or covered Retiree acquires the Dependent as follows:
    - (1) Legal spouses - the date of marriage.
    - (2) Natural children - the date of birth.
    - (3) Children in the process of being adopted through an agency adoption are deemed acquired on the date the adoption contract is executed by the Employee and the adoption agency.
    - (4) Children in the process of being adopted through a private adoption are deemed acquired on the date of the execution of the Act of Voluntary Surrender in favor of the Employee, provided certification of the execution date and the date the act becomes irrevocable is furnished by the appropriate clerk of court, or the date of the first court order granting legal custody, whichever occurs first.
    - (5) Other children for whom Employee has legal custody - the date of the court order awarding legal custody.

(6) Grandchildren not in the legal custody of the Employee:

- (a) the date of birth if the grandchild is dependent on the Employee for support and living in the household of the Employee and if the grandchild's parent is a covered Dependent of the Employee; or
- (b) the date the grandchild meets the above criteria, if not met on the grandchild's date of birth.

A DEPENDENT MAY NOT BE COVERED BY MORE THAN ONE EMPLOYEE.

#### **D. Application for Coverage**

1. Every Eligible Person may apply for coverage under the Benefit Plan and may include any Eligible Dependents in such application.
2. The Group will submit any such applications to the Company as a prerequisite to coverage under the Benefit Plan.
3. No person for whom coverage is sought will be covered under the Benefit Plan unless the application for coverage has been approved by Group and Company, and such approval has been evidenced by the issuance of an I.D. card or other written notice of approval. Payment of fees to the Company for any person for whom coverage is sought will not effectuate coverage unless and until the Company's I.D. card or other written approval has been issued, and in the absence of such issuance, the Company's liability will be limited to refund of the amount of fees paid.
4. The Group Benefit Plan and coverage under it will not be issued or renewed unless the percent of Eligible Persons specified in the Application for Group Coverage is enrolled.

#### **E. Available Classes of Coverage**

1. Subscriber Only coverage means coverage for the Subscriber only.
2. Subscriber and Spouse coverage means coverage for the Subscriber and his spouse.
3. Subscriber and Dependent coverage means coverage for the Subscriber and one or more Dependents (child, grandchild, or parent).
4. Subscriber and Family coverage means coverage for the Subscriber, his spouse, and one or more Dependents.

#### **F. Change of Classification**

1. Adding or Deleting Dependents

The Member must notify the Company whenever a Dependent is added to, or deleted from, the Members coverage, regardless of whether the addition or deletion would result in a change in the Class of Coverage. Notice must be provided to the Company within thirty (30) days of the addition or deletion.

2. Notification of Change

The Employee will be responsible for notifying the Company of any change in classification of coverage affecting the Employee's contribution amount. Any such failure later determined will be corrected on the first (1<sup>st</sup>) day of the following month.

#### **G. Effective Date**

1. Employees

Unless the Employee Deferral Rule as stated below applies, coverage for an Employee who makes written application for coverage within thirty (30) days after the date of employment and agrees to make the required Employee contribution is effective as follows:

- a. If employment begins on the first day of the month, coverage is effective the first day of the following month.
- b. If employment begins on the second day of the month or after, coverage is effective the first day of the second month following employment.
- c. An Employee who completes an application for coverage after thirty (30) days following the date of employment will be considered a late applicant. Coverage for late applicants becomes effective as specified in the section below entitled "Late Applicants."
- d. An Employee who transfers employment to another participating employer must complete a transfer form within thirty (30) days following the date of transfer in order to maintain coverage without interruption. An employee who completes a transfer form after thirty (30) days following the date of transfer will be considered a late applicant and will be subject to the provisions as specified in the section below entitled "Late Applicants."

## 2. Retirees

Coverage for a Retiree who enrolls within thirty (30) days after the date of retirement is effective on the first day of the month following the date of retirement, if the Group and the Retiree have agreed to make and are making the required contributions. **Retirees are not eligible as late applicants.**

## 3. Dependents of Employees

Unless the Dependent Deferral Rule applies, coverage for an Employee's Dependent is effective on the date the Employee becomes eligible to carry Dependent coverage if the Employee has made written application within thirty (30) days from the Dependent's eligibility date and agrees to make the required Employee contributions. Coverage for Dependents for whom late application is made becomes effective as specified under "**Late Applicants.**"

## 4. Dependents of Retirees

Unless the Dependent Deferral Rule applies, coverage for a Retiree's Dependent is effective on the first day of the month following the date of retirement if the Retiree and Dependents were covered immediately prior to retirement and application is made within thirty (30) days of the date of retirement. Unless the Dependent Deferral Rule applies, coverage for Dependents of Retirees first becoming eligible for Dependent Coverage following the date of retirement shall be effective on the date of marriage (for new spouses of Retirees), the date of birth (for newborn children of Retirees), or the date the Dependent was acquired (for all other classes of Dependents), if written application is made within thirty (30) days of the Dependent's eligibility date. Coverage for Dependents for whom late application is made becomes effective as specified under "**Late Applicants.**"

## 5. Deferral Rules

- a. **Employee Deferral Rule:** The Effective Date of coverage will be deferred if the Employee is confined at home, in a Hospital, nursing home, or elsewhere by reason of disease, illness, accident, or injury on this date. Coverage will become effective on the date of completion of one (1) full day of work. This return to active work requirement will not defer the Effective Date of coverage if the Employee's normal place of employment is not open on the day he would otherwise have returned to work.

If an Employee is on an approved leave of absence on the date he would normally have returned to work, coverage will be effective on the day he would normally have returned to active work.

- b. **Dependent Deferral Rule:** Coverage of a Dependent, other than a newborn child of the Employee or the Employee's legal spouse, is not effective on the date he would otherwise be covered if he is confined at home, in a nursing home, Hospital, or elsewhere, by reason of disease, illness, accident, or injury on that date. Coverage is deferred until the date confinement terminates or disability ends, whichever is later.

If a Dependent is so confined on an amended Effective Date, any amendment of Benefits will not be applicable to him until the day immediately following the end of the confinement or the disability, whichever is later.

**NOTE:** As referenced above and in LIMITATIONS AND EXCLUSIONS, Health Care expenses incurred by a Member during a confinement or disability already in progress on the Member's Effective Date are not covered.

## 6. Late Applicants

The Effective Date of coverage for an eligible Employee who applies for coverage after thirty (30) days from the eligibility date and for an eligible Dependent of an Employee or Retiree for whom application was not made within thirty (30) days from the date of acquisition of the Dependent shall be:

- a. the first day of the month following the date all required forms are received, if received prior to the fifteenth of the month; or
- b. the first day of the second month following the date all required forms are received, if received on or after the fifteenth of the month.

All late applicants may be required to complete a health questionnaire and are subject to the limitation for Pre-Existing Conditions for late applicants as noted in the Schedule of Benefits and Limitations and Exclusions section of the Benefit Plan. This paragraph shall not apply to military reservists or national guardsmen ordered to active duty who return to their employment with the Group and reapply for coverage within thirty (30) days of the date of reemployment. Their coverage will be reinstated effective on the date of return to employment.

Medical expenses incurred during the first twelve (12) months that coverage for the Employee or Dependent is in force under the Benefit Plan will not be considered as covered medical expenses if they are in connection with a disease, illness, accident or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) month period immediately prior to the Effective Date of coverage. The provisions of this paragraph do not apply to pregnancy. This provision does not apply to Dependents under age 19. Dependents under age 19 are never subject to a Pre-Existing Condition Exclusion Period.

If the Employee or Dependent was previously covered under a group health plan, health insurance coverage, Part A or Part B of Title XVII of the Social Security Act (Medicare), Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under Section 1928 thereof, or State Children's Health Insurance Program ("CHIP") or other Creditable Coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and the rules and regulations promulgated pursuant thereto, the duration of the prior coverage will be credited against (any Pre-Existing Condition Exclusion Waiting Period as long as the prior coverage did not end more than sixty-three (63) days before the date of enrollment for coverage in this Benefit Plan.

## H. Special Enrollment

### 1. Loss of Coverage for Active Employees

Special enrollment will be permitted for eligible Employees or Dependents for whom the option to reenroll for coverage was previously declined because such Employees or Dependents had other coverage which has terminated due to:

- a. Loss of eligibility as a result of legal separation, divorce, termination of employment, reduction in the number of hours of employment, or death of the plan participant; or
  - b. Termination of employer contributions to the coverage. Individuals who lose coverage due to non-payment of premiums or for cause (i.e., filing a fraudulent claim) are not Special Enrollees; or
  - c. The Employee or Dependent having had COBRA continuation of coverage under another plan, and the COBRA continuation of coverage has been exhausted, as provided in HIPAA; or
  - d. The applicant incurs a claim that would meet or has met a lifetime limit on all Benefits on their current plan of coverage; or
  - e. Their current plan of coverage no longer offers any Benefits to the class of similarly situated individuals.
2. Loss of Coverage for Retirees

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

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

Special enrollment will be permitted for eligible Employees or Dependents for whom the option to enroll for coverage was previously declined if the Employee acquires a new Dependent by marriage, birth, adoption, or placement for adoption.

4. Application for Coverage

Special enrollment application must be made within thirty (30) days of the termination date of the prior coverage or within thirty (30) days of the date the new Dependent is acquired. Persons eligible for special enrollment for whom application is made more than thirty (30) days after eligibility will be considered late applicants and subject to the provisions stated above entitled “**Late Applicants.**”

Special enrollment applicants may be required to complete a health questionnaire and may be subject to the limitation for Pre-Existing Conditions.

5. Effective Date of Coverage Shall Be:

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

- (a) For loss of other coverage or marriage, the first of the month following the date of the receipt by the Company of all required forms for enrollment;
- (b) For birth of a Dependent, the date of birth;
- (c) For adoption, the date of adoption or placement for adoption;

6. Special Enrollment of a Dependent Child Due to Loss of Coverage Under the Louisiana Children's Health Insurance Program or a Medicaid Program
  - a. This Benefit Plan shall provide for a Special Enrollment Period for an employee or family Dependent(s) if either (1) covered under Medicaid or State Children's Health Insurance Program ("CHIP"), and loses that coverage because of loss of eligibility; or (2) becomes 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 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, 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.

#### **I. Other Enrollment Information**

1. Creditable coverage before a sixty-three (63) day break in coverage is counted for certain individuals who elected COBRA coverage under a special second COBRA election period. The special second COBRA election period is available to certain employees who have been affected by import competition or shifts abroad of production capacity and who are receiving trade adjustment assistance under the Trade Act of 2002, and as amended by ARRA. If the Member qualifies or may qualify for assistance under the Trade Act of 2002, and as amended by ARRA, the Member should contact the Group for additional information.
2. The Subscriber's Enrollment Date and that of any of the Subscriber's Dependents into the Subscriber's Group health plan is needed to administer any applicable Pre-Existing Condition exclusion provision. If the Subscriber's Group health plan has switched carriers or administrators, We may not have received this enrollment information timely. In order to avoid delays in setting up coverage with Us, the following guidelines are used to establish the Enrollment Date for Members that were insured under their Group's prior health plan and who are moving with the Group as it becomes insured or administered by HMO Louisiana, Inc.
3. Unless otherwise indicated by the plan or the Subscriber, the Enrollment Date into the Group health plan for all Members insured with the previous carrier will be the Subscriber's hire date. If no hire date is provided, We will not delay the Member's enrollment, but will assign the Group's Effective Date as the Member's Enrollment Date into the Group health plan. If the Member was not insured by the previous carrier because he was serving the plan's Eligibility Waiting Period, the Member's Enrollment Date will be the Subscriber's hire date. If the plan did not have a carrier or administrator prior to enrolling with Us, the Member's Enrollment Date into this health plan will be the Group's Effective Date.
4. For Members who enroll subsequent to the date the Group becomes effective with Us, the subsequent Member's Enrollment Date will be either the Subscriber's hire date or the Member's Effective Date of coverage into the Group plan. This Enrollment Date depends whether the Member is enrolling initially when the Subscriber is hired, or as a Special or Late Enrollee.

### **ARTICLE III.**

### **BENEFITS PROVIDED**

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

## A. Benefit Categories

1. The **HMO Louisiana, Inc.** Point of Service Benefit Plan includes the following categories of Benefits:
  - a. **Network Benefits**
    - (1) Benefits for care received from a Network Provider and Authorized by Us where required.
    - (2) Benefits for care received from a Non-Network Provider that We have Authorized where required.
  - b. **Non-Network Benefits.**
    - (1) Benefits for care received from Non-Network Providers that We have not Authorized.
    - (2) Benefits for care that have not been Authorized by Us where required.
  - c. **Dependent Out-of-Area Benefits** - Benefits for Covered Services provided to the Subscriber's Dependents who are regularly located outside of the Subscriber's defined Service Area and who enroll for Dependent Out-of-Area Benefits.

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

2. **Network Benefits**
  - a. The Member must pay all Deductible Amounts, Copayments and any applicable Coinsurance percentages shown in the Schedule of Benefits for a specified Covered Service each time the Covered Service is rendered, subject to any limitations or maximum Benefits shown.
  - b. If a Coinsurance is shown for a Covered Service, the Member must pay only that Coinsurance percentage, subject to any limitations or maximum Benefits shown in the Schedule of Benefits. The Group will provide Benefits for Covered Services based on the Allowable Charges for those services for which a Coinsurance percentage is applicable.
  - c. Deductible Amounts, Copayments and Coinsurance percentages are subject to change from time to time.
3. **Non-Network and Dependent Out-of-Area Benefits**
  - a. After any Deductible Amounts shown in the Schedule of Benefits have been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Group will provide Benefits in the Coinsurance percentages shown in the Schedule of Benefits toward Allowable Charges for Covered Services rendered to a Member during a Benefit Period. The Group's actual payment to a Provider or payment to the Member satisfies the Group's obligation to provide Benefits under this Benefit Plan
  - b. If more than one enrolled member of a family incurs charges for Covered Services as a result of injuries received in the same accident, then only one Benefit Period Deductible Amount will be applied to the aggregate of charges for Covered Services which are incurred by the Subscriber or his covered Dependent(s) during that Benefit Period as a result of those injuries.
  - c. Deductible Amounts, Copayments and Coinsurance percentages are subject to change from time to time.
  - d. We will apply the Member's Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Member, then when the Member receives Covered Services from another Provider, that Provider also collects the Member's Deductible Amount. This generally occurs when the Member's Claims have not been received and processed by Us. Our system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Member may need to pay toward the Deductible Amount until his Claims

are submitted and processed, showing that the Deductible Amount has been met. If the Member overpays his Deductible Amount, the Member is entitled to receive a refund from the Provider in which the overpayment was made.

**4. Out-of-Pocket Amounts may be different for Network, Non-Network, and Dependent Out-of-Area Benefits**

a. The following accrue toward the Out-of-Pocket Amount, as shown in the Schedule of Benefits. After the Member has met the applicable Out-of-Pocket Amount, We will pay one hundred percent (100%) of the Allowable Charge for the following Covered Services.

(1) Coinsurance;

(2) Ambulatory Surgical Facility and Outpatient Surgical Facility Copayments.

b. The following do not apply toward satisfying the Out-of-Pocket Amount:

(1) Deductible Amounts;

(2) Copayments that the Member pays other than Ambulatory Surgical Facility and Outpatient Surgical Facility Copayments; and/or

(3) any charges in excess of the Allowable Charge;

(4) any penalties the Member or Provider must pay;

(5) charges for non-Covered Services; and:

(6) any amounts paid by the Member other than those shown in a. above.

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

**B. Accumulator Transfers**

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

**ARTICLE IV.**

**HOSPITAL BENEFITS**

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

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

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

**A. Inpatient Bed, Board and General Nursing Service**

1. In a semi-private room, where the Hospital provides semi-private rooms. The average semi-private room rate will be allowed toward a private room accommodation. If the facility does not offer semi-private rooms, the lowest private room rate will be allowed toward a private room accommodation.
2. In a Special Care Unit for a critically ill Member requiring an intensive level of care.
3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital, for the maximum number of days per Benefit Period shown in the Schedule of Benefits. In addition, the Admission to a Skilled Nursing Facility or Unit must occur within fourteen (14) days of a Hospital confinement of three (3) or more days for the same or related condition.
4. In a Residential Treatment Center for Members with Mental Disorders and Alcohol and/or Drug Abuse Benefits.

**B. Other Hospital Services (Inpatient and Outpatient)**

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

**C. Inpatient Hospital Facility Copayment**

The Inpatient Hospital Facility Copayment, as shown in the Schedule of Benefits, is applicable to each Inpatient Admission to a Hospital facility.

The Inpatient Hospital Facility Copayment is separate from the Benefit Period Deductible Amount and any other Copayment amounts of the Benefit Plan. In addition, the Inpatient Hospital Facility Copayment does not apply toward satisfaction of the Out-of-Pocket Amount.

**ARTICLE V. SURGICAL AND MEDICAL 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 Member must pay any applicable Deductible Amounts and Coinsurance 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 Us and is that period of time which is appropriate as routine care for the particular surgical procedure.

- b. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.
2. Multiple Surgical Procedures - When Medically Necessary multiple procedures (concurrent, successive, or other multiple surgical procedures) are performed at the same surgical setting, Benefits will be paid as follows:
    - a. Primary Procedure
      - (1) The primary or major procedure will be the procedure with the greatest value based on the Allowable Charge.
      - (2) Benefits for the primary procedure will be based on the Allowable Charge.
    - b. Secondary Procedure(s)

The secondary procedure(s) is a procedure(s) performed in addition to the primary procedure which adds significant time, risk, or complexity to the Surgery. The Allowable Charge for the secondary procedure will be based on a percentage of the Allowable Charge that would be applied had the secondary procedure been the primary procedure. Benefits will not exceed fifty percent (50%) of the Allowable Charge for each procedure.
    - c. Incidental Procedure

No Benefits are allowed for an incidental procedure.
    - d. Unbundled Procedure(s)
      - (1) Unbundling occurs when two (2) or more procedure codes are used to describe Surgery performed when a single, more comprehensive procedure code exists that accurately describes the entire Surgery performed. The unbundled procedures will be rebundled for assignment of the proper comprehensive procedure code as determined by Us.
      - (2) The Allowable Charge includes the rebundled procedure. The Group will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as We determine.
    - e. Mutually Exclusive Procedure(s)
      - (1) Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made.
      - (2) The Allowable Charge includes for all procedures performed at the same surgical setting. Procedure(s) which are not considered Medically Necessary will not be covered.

3. Assistant Surgeon

An assistant surgeon is a Physician, licensed physician assistant, certified registered nurse first assistant (CRNFA), registered nurse first assistant (RNFA), or certified nurse practitioner. Coverage for an assistant surgeon is provided only if the use of an assistant surgeon is required with reference to nationally established

guidelines. The Allowable Charge for the assistant surgeon is based on a percentage of the fee paid to the primary surgeon.

#### 4. Anesthesia

- a. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by Us. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.
- b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless We determine otherwise.
- c. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

#### 5. Second Surgical Opinion

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

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

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

### **C. Outpatient Medical and Surgical Services**

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

### **D. Pre-Admission Testing Benefits**

Pre-Admission Diagnostic Services in the Outpatient department of a Hospital within seven (7) days of a scheduled Admission to that Hospital.

### **E. Breast Reconstructive Surgical Services**

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

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

**ARTICLE VI. PREVENTIVE OR WELLNESS CARE**

**Network, Non-Network and Dependent Out-of-Area**

The following services are available to a Member. The Member must pay all Copayments, any applicable Deductible Amounts and Coinsurance percentages, and is subject to other limitations shown in the Schedule of Benefits.

**A. Well Woman Examinations, Physical Examinations, Immunizations, and other Preventive or Wellness Care Benefits**

- 1. One (1) visit per Benefit Period to an obstetrician/gynecologist for a routine gynecological exam.
- 2. One (1) routine Pap Smear per Benefit Period.
- 3. One (1) Mammography examination every twelve (12) months, or more frequently if recommended by the Member's Physician.
- 4. One (1) routine physical examination per Member each Benefit Period, including sports exam for a minor Dependent. Related diagnostic tests performed during the same visit are also included.
- 5. Well Baby Care.
- 6. Immunizations recommended by the Member's Physician. The Deductible Amount does not apply.
- 7. One (1) Digital rectal examination and prostate-specific antigen (PSA) test per Benefit Period
- 8. One (1) colonoscopy exam every five (5) years for Members over age fifty (50); or for Members age forty (40) or older if recommended by the Member's Physician.
- 9. Preventive services in the following categories, referred to as "Recommended Preventive Services," are covered at no cost to the Member when services are obtained from a Network Provider. In-Network Physician office visits are covered at no cost to the Member when required by law.
  - a. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. (Recommendations of the United States Preventive Services Task Force are not required to be covered immediately after the release of the recommendation or guideline. Timing rules apply by law.)
  - b. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
  - c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

- d. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Specific Preventive or Wellness Care services may be included or excluded from this Benefit if shown in the Schedule of Benefits.

## **B. Colorectal Cancer Screening Benefits**

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

## **ARTICLE VII.**

## **PREGNANCY CARE BENEFITS**

**To receive Network Benefits, the Member must obtain Authorization for certain services as shown in the Schedule of Benefits and the Authorization of Services and Supplies Article.** Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a patient covered as a Subscriber or Dependent wife of a Subscriber whose coverage is in effect at the time such services are furnished in connection with her pregnancy. An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child **only if** the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a newborn's stay exceeds that of the mother. An Authorization is also required for a newborn that is admitted separately because of neonatal complications. Benefits for treatment of ectopic pregnancies and spontaneous abortions are available for all covered Members under ARTICLE IV and ARTICLE V of this Benefit Plan.

Pregnancy Care Benefits when services are rendered by an HMO Provider are subject to the Pregnancy Care Copayment amount shown in the Schedule of Benefits.

Benefits rendered by all other Providers are subject to the Benefit Period Deductible Amount, if applicable, and applicable Coinsurance percentage shown in the Schedule of Benefits. In addition, Benefits rendered for subsequent visits, delivery and facility charges are subject to the Benefit Period Deductible Amount and applicable Coinsurance percentage shown in the Schedule of Benefits.

Pregnancy Care Benefits are as follows:

### **A. Surgical and Medical Services**

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

### **B. Facility Services**

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

### **C. Benefits**

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

### **D. Statement of Rights under the Newborns' and Mothers' Health Protection Act**

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

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

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

## **ARTICLE VIII.**

## **NEWBORN CARE**

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

- A. Surgical and medical services rendered by a Physician, for treatment of illness, prematurity, postmaturity, or congenital condition of a newborn and circumcision. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.
  1. Network, Non-Network and Dependent Out-of-Area Benefits: The Member must pay the Deductible, all applicable Coinsurance and Copayments as shown in the Schedule of Benefits.
- B. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, prematurity, postmaturity, or congenital condition of a newborn. Charges for a well newborn which are billed separately from the mother's Hospital bill are not covered.
  1. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care.
  2. Network Benefits: An Inpatient Hospital Admission Copayment applies to the Admission of an ill newborn for treatment in a Hospital. We will provide Benefits of one hundred percent (100%) of the Allowable Charges for such treatment, less the Member's Copayment.
  3. Non-Network and Dependent Out-of-Area Benefits: Benefits for Hospital Covered Services for treatment of an ill newborn will be determined by applying the Coinsurance shown in the Schedule of Benefits to Allowable Charges for those services.

## **ARTICLE IX.**

## **REHABILITATIVE CARE BENEFITS**

**To receive Network Benefits, the Member must obtain Authorization for certain services as shown in the Schedule of Benefits and the Authorization of Services and Supplies Article.**

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

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

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

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

### **A. Occupational Therapy Benefits**

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

### **B. Physical Therapy Benefits**

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license. Physical Therapy is not covered when maintenance level of therapy is attained.
2. Physical Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.
3. A licensed physical therapist may perform an initial evaluation or Consultation of a screening nature to determine the need for Physical Therapy.
4. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances and Benefits are provided for the following:
  - a. To children with a diagnosed developmental disability pursuant to the patient's plan of care.

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

### **C. Speech/Language Pathology Therapy Benefits**

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

### **D. Chiropractic Services Benefits**

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

## **ARTICLE X. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT**

**To receive Network Benefits, the Member must obtain Authorization for certain services as shown in the Schedule of Benefits and the Authorization of Services and Supplies Article.** The following services are available to a Member. The Member must pay all Copayments, applicable Deductible Amounts and Coinsurance percentages. These services, supplies or equipment may also be subject to other limitations shown in the Schedule of Benefits.

### **A. Ambulance Service Benefits**

- 1. The following Ambulance Services for local transportation are covered when Medically Necessary:
  - a. to or from the nearest Hospital that can provide services appropriate to a Member's condition for an illness or injury requiring Hospital care;
  - b. to the nearest Hospital or neonatal Special Care Unit for newborn infants for treatment of illnesses, injuries, congenital birth defects and complications of premature birth which require that level of care;

2. Benefits for air Ambulance Services are available only if this type of Ambulance Service is requested by policing or medical authorities at the site in an Emergency situation or if the Member is in a location that cannot be reached by a ground ambulance.
3. In a non-Emergency situation, air Ambulance Service is not covered unless the Member requests and receives Authorization from Us prior to the service being rendered.
4. Ambulance Service Benefits are as follows:
  - a. Network, Non-Network, and Dependent Out-of-Area Benefits: Benefits for Ambulance Services will be paid by applying the Deductible Amount and the Coinsurance shown in the Schedule of Benefits.
  - b. If a Member pays a periodic fee to an ambulance membership organization with which We do not have a Provider Agreement, Benefits for expenses that the Member incurs for Ambulance Services will be based on any obligation the Member must pay that is not covered by the fee.
  - c. No Benefits are available if transportation is provided for the Member's comfort or convenience or when a Hospital transports Members between parts of its own campus..

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non\_Limb) are covered at the Coinsurance percentages shown in the Schedule of Benefits.

1. Durable Medical Equipment
  - a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be provided mainly for the comfort or convenience of the Member or others. In addition, the equipment must meet all of the following criteria:
    - (1) It must withstand repeated use,
    - (2) It must be primarily and customarily used to serve a medical purpose,
    - (3) It must be generally not useful to a person in the absence of illness or injury, and
    - (4) It must be appropriate for use in the patient's home.
  - b. Benefits for rental or purchase of Durable Medical Equipment.
    - (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge).
    - (2) At Our option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.
    - (3) Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Member selects deluxe equipment solely for his comfort or convenience.
    - (4) Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
    - (5) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.

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

c. Limitations in connection with Durable Medical Equipment.

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

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

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

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

2. Orthotic Devices

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

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

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

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

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

e. No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

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

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

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

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

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

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

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

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

#### **C. Private Duty Nursing Services**

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

#### **D. Vision Care - All Benefit Categories**

1. One (1) routine eye examination as shown in the Schedule of Benefits.
2. A Member must pay the Vision Care Copayment shown in the Schedule of Benefits.

#### **E. Out-of-Area Emergency Medical Services**

1. A Member must pay the Deductible and Coinsurance, shown in the Schedule of Benefits, for each visit the Member makes to a Hospital or Allied Health Facility for Emergency Medical Services while outside his Service Area.
2. A Member must pay a Physician's Copayment for each visit the Member makes to a Physician's office for Emergency Medical Services while outside his Service Area.

#### **F. Disposable Medical Equipment or Supplies**

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

## **G. Coverage for Diabetes**

1. Coverage is available for the equipment, supplies, and Outpatient self-treatment training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Member's Physician.
2. A one time evaluation and training program per Member for diabetes self-management is covered, subject to the following:
  - a. The program must be determined to be Medically Necessary by a Physician and provided by a licensed health care professional that certifies that a Member has successfully completed the training program.
3. Additional diabetes self-management training is covered subject to the following:
  - a. A Physician prescribes additional training based upon Medical Necessity because of a significant change in the Member's symptoms or conditions.

## **H. Bone Mass Measurement**

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

1. Is an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;
2. Is an individual receiving long-term steroid therapy; or
3. Is an individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.
4. Deductible, Coinsurance, and /or copayment amounts are applicable.

## **I. Hospice and Home Health Care Benefits**

1. Hospice Care is covered up to the Lifetime Maximum number of days for Inpatient and/or Outpatient care received for each Member. Prior Authorization is required prior to receiving services as set out in the Authorization of Services and Supplies section of this Benefit Plan. Benefits will be reduced by the Coinsurance percentage shown in the Schedule of Benefits if prior Authorization is not obtained.
2. Home Health Care services provided to a Member in lieu of an Inpatient Hospital Admission are covered up to the maximum number of visits, each Benefit Period, as shown in the Schedule of Benefits. Prior Authorization is required prior to receiving services as set out in the Authorization of Services and Supplies section of this Benefit Plan. Benefits will be reduced by the Coinsurance percentage shown in the Schedule of Benefits if prior Authorization is not obtained.

## **J. Permanent Sterilization Procedures**

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

## **K. 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.

## **L. Cardiac Rehabilitation**

Benefits will be provided for Covered Services rendered to a Member for cardiac rehabilitation. Covered Services must be:

1. performed under the supervision of a Physician; and
2. in connection with a myocardial infraction, angioplasty (with or without stenting), or cardiac bypass Surgery; and
3. initiated within twelve (12) weeks after other treatment for the medical condition ends.

#### **M. Copayment Services**

1. Copayment services means the following Outpatient services when rendered in a primary provider's (general practice, family practice, pediatric, internal medicine, obstetrics, gynecology, licensed professional counselor, master of social work, physiotherapy, psychiatry, psychology, substance abuse counselor, chiropractic) office or clinic, or when rendered in an Urgent Care Center or federally qualified rural health clinic:
  - a. office visit charges and Consultation;
  - b. x-rays;
  - c. laboratory tests. Laboratory tests that are processed and completed within the Physician's office or clinic will be subject to the Physician office visit Copayment. Laboratory tests that are sent out of the Physician's office or clinic for processing may be subject to the Deductible Amount and Coinsurance;
  - d. machine tests (except for MRI);
  - e. injections,
  - f. surgical procedures; and/or
  - g. Preventive or Wellness Care.
2. Copayment services do not include the following services and/or supplies. The following services and/or supplies are subject to the Benefit Period Deductible Amount and applicable Coinsurance percentage shown in the Schedule of Benefits:
  - a. allergy testing, allergy serums, and vials of allergy medications;
  - b. Physical Therapy, Occupational Therapy, and Speech Therapy;
  - c. medical and surgical supplies and/or
  - d. Durable Medical Equipment.

#### **N. Clinical Trial Participation**

1. Patient costs are covered when incurred for treatment provided in a clinical trial for cancer, as described in this paragraph. Coverage will be subject to any applicable Copayment, Deductible, or Coinsurance amounts shown in the Schedule of Benefits.
2. The following services are not covered:
  - a. Non-healthcare services provided as part of the clinical trial;
  - b. Costs for managing research data associated with the clinical trial;
  - c. Investigational drugs or devices; and/or

- d. Services, treatment or supplies not otherwise covered under this Benefit Plan.
- 3. Investigational treatments and associated protocol related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:
  - a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
  - b. The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.
  - c. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
    - (1) One of the United States National Institutes of Health.
    - (2) A cooperative group funded by one of the National Institutes of Health.
    - (3) The FDA, in the form of an investigational new drug application.
    - (4) The United States Department of Veterans Affairs.
    - (5) The United States Department of Defense.
    - (6) A federally funded general clinical research center.
    - (7) The Coalition of National Cancer Cooperative Groups.
  - d. The proposed protocol must have been reviewed and approved by a qualified institutional review board.
  - e. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
  - f. There must be no clearly superior, non-investigational approach.
  - g. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.
  - h. The patient has signed an institutional review board approved consent form.

#### **O. Sleep Studies**

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

#### **P. Dietician Visits**

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

## **Q. Autism Spectrum Disorders (ASD)**

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

ASD Benefits are subject to the Co-payments, Deductibles, and Coinsurance amounts that are applicable to the Benefits obtained. (Example: A Member obtains speech therapy for treatment of ASD. Member will pay the applicable Co-Payment, Deductible or Coinsurance amount shown on the Schedule of Benefits for speech therapy.

## **ARTICLE XI. MENTAL DISORDERS, ALCOHOL AND/OR DRUG ABUSE BENEFITS**

**The Member must obtain Authorization for certain services as shown in the Schedule of Benefits and the Authorization of Services and Supplies Article.**

- A. Benefits for the treatment of Mental Disorders are available subject to any limitations shown in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Coverage for treatment of Mental Disorders does **not** include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
- B. Coverage for treatment of alcohol and/or drug abuse is available subject to any limitations shown in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. 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.

## **ARTICLE XII. ORAL SURGERY BENEFITS**

**To receive Network Benefits, the Member must obtain care from a Network Provider and obtain Authorization for certain services as shown in the Schedule of Benefits and the Authorization of Services and Supplies Article.** For Oral Surgery Benefits, providers in the HMO Network and the Blue Cross and Blue Shield of Louisiana's dental network are considered Network Providers. Access both networks online at [www.bcbsla.com](http://www.bcbsla.com), or call the customer service telephone number on Your I.D. card for copies of the directories. Coverage is provided only for the following services or procedures:

- A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- B. Extraction of impacted teeth.
- C. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.)
- D. Excision of exostoses or tori of the jaws and hard palate.
- E. Incision and drainage of abscess and treatment of cellulitis.
- F. Incision of accessory sinuses, salivary glands, and salivary ducts.
- G. Anesthesia for the above services or procedures when rendered by an oral surgeon.

- H. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia Benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders.
- J. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To determine if the Member is eligible for these Benefits, please call Our Customer Service Unit at the phone number on the Member's I.D. card, and ask to speak to a Case Manager.

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

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

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

**A. Acquisition Expenses**

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

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

**B. Organ, Tissue and Bone Marrow Transplant Benefits**

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) or a Blue Cross and Blue Shield of Louisiana (BCBSLA) Network facility, unless otherwise approved by Us in writing. To locate a BDCT or BCBSLA Network facility, Members should contact Our Customer Service Department at the number listed on their I.D. card.
2. The Organ, Tissue and Bone Marrow Transplant Benefits are shown in the Schedule of Benefits and are not covered under the Non-Network Benefit category. Benefits are provided for Network services and for Dependent Out-of-Area services.
3. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs administered during an Inpatient Admission only. No Benefits are available under this Benefit Plan for immunosuppressive drugs received after an Inpatient Admission ends.

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

**C. Solid human organ transplants of the:**

1. Liver;

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

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

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

These following tissue transplants are covered:

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

**E. Bone marrow transplants**

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

**ARTICLE XIV. AUTHORIZATION OF SERVICES AND SUPPLIES**

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

A Member may generally obtain medical care from any Provider. Benefits will be paid at the highest Network level when care is received from a Network Provider, and the services have been Authorized as Medically Necessary before the services are rendered. Benefits will be paid at the lower Non-Network level when care is either received from a Non-Network Provider or a required Authorization is not obtained.

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

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

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

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

## **B. Authorization of Admissions**

### **1. Authorization of Elective Admissions**

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

### **2. Authorization of Emergency Admissions**

- a. It is the Member's responsibility to ensure that his Physician or Hospital, or a representative thereof, notifies the Company's Care Management Department of all Emergency Inpatient Hospital Admissions to guarantee coverage. Within forty-eight (48) hours of the Emergency Admission, the Company must be notified (by calling the telephone number shown in the Schedule of Benefits or the Member's I.D.

card) regarding the nature and purpose of the Emergency Admission. The Company may waive or extend this time limitation if it determines that the Member is unable to timely notify or direct his representative to notify the Company of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend the Company must be notified on the next working day. The appropriate length of stay for the Emergency Admission will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.

- b. If Authorization is denied by Us for an Admission to any facility, the Admission will not be covered and the Member must pay all charges incurred for Hospital services during the Admission.
  - c. If Authorization is not requested, in addition to any Deductible Amount and Coinsurance amount required in this Benefit Plan, the Member will be responsible for all charges for Hospital services not specifically listed as Covered Services during the Admission and for the penalty amount shown in the Schedule of Benefits. Additionally, all days not Authorized will be reviewed for Medical Necessity and could be denied.
  - d. Additional amounts the Member is responsible for because Authorization of an Emergency Admission was denied or not requested will not apply toward the Out-of-Pocket Amount.
3. Concurrent Review
- a. When We Authorize a Member's Inpatient stay, We will Authorize his stay in the Hospital for a certain number of days. If the Member has not been discharged on or before the last Authorized day, and the Member needs additional days to be Authorized, the Member must make sure his Physician or Hospital contacts Our Care Management Department to request Concurrent Review for Authorization of additional days. This request for continued hospitalization must be made on or before the Member's last Authorized day so We can review and respond to the request that day. If We Authorized the request, We will again Authorize a certain number of days, repeating this procedure until the Member is either discharged or the Member's continued stay request is denied.
  - b. If We do not receive a request for Authorization for continued stay on or before the Member's last Authorized day, no days are approved past the last Authorized day, and no additional Benefits will be paid unless We receive and Authorize another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and We determine that it is not Medically Necessary for the Member to receive continued hospitalization or hospitalization at the level of care requested, We will notify the Member and his Providers, in writing, that the request is denied and no additional days are Authorized.
  - c. If We deny a Concurrent Review request or level of care request for Hospital Services, We will notify the Member, his Physician and the Hospital of the denial. If the Member elects to remain in the Hospital as an Inpatient thereafter, or at the same level of care, the Member will not be responsible for any charges unless he is notified of his financial responsibility by the Physician or Hospital in advance of incurring additional charges.
  - d. Charges for non-Authorized days in the Hospital that the Member must pay will not apply toward satisfying the Out-of-Pocket Amount.

### **C. Authorization of Other Covered Services and Supplies**

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

## **D. Appeals**

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

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

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

## **ARTICLE XV.**

### **DISEASE MANAGEMENT**

#### **Qualification**

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

#### **Disease Management Benefits**

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

## **ARTICLE XVI.**

### **CASE MANAGEMENT**

- A. The Member may qualify for Case Management services, at the Company's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.
- B. The role of Case Management is to service the Member by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.
- C. The Company's determination that a particular Member's medical condition renders the Member a suitable candidate for Case Management services will not obligate the Company to make the same or similar determination for any other Member. The provision of Case Management services to one Member will not entitle any other Member to Case Management services or be construed as a waiver of the Company's right to administer and enforce this Benefit Plan in accordance with its express terms.
- D. Unless expressly agreed upon by the Company, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Member is receiving Case Management services.

- E. The Member's Case Management services will be terminated upon any of the following occurrences:
1. We determine, in Our sole discretion, that the Member is no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.
  2. The short and long-term goals established in the Case Management plan have been achieved, or the Member elects not to participate in the Case Management plan.

**ARTICLE XVII. ALTERNATIVE BENEFITS**

- A. The Member may qualify for Alternative Benefits, at the Company's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Member and to the Company.
- B. The Company's determination that a particular Member's medical condition renders the Member a suitable candidate for Alternative Benefits will not obligate the Company to make the same or similar determination for any other Member; nor will the provision of Alternative Benefits to a Member entitle any other Member to Alternative Benefits or be construed as a waiver of the Company's right to administer and enforce this Benefit Plan in accordance with its express terms.
- C. Unless expressly agreed upon by the Company, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Member is receiving Alternative Benefits.
- D. Alternative Benefits provided under the Article are provided in lieu of the Benefits to which the Member is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Benefit Plan.
- E. The Member's Alternative Benefits will be terminated upon any of the following occurrences:
1. We determine, in Our sole discretion, that the Member is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.
  2. The Member receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by Us.

**ARTICLE XVIII. LIMITATIONS AND EXCLUSIONS**

- A. Services, supplies and treatment for services that are not covered under this Benefit Plan and complications from services, supplies and treatment for services that are not covered under this Benefit Plan are excluded.
- B. Any of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown in the Schedule of Benefits. Unless otherwise shown as covered in the Schedule of Benefits, the following are not covered, **REGARDLESS OF CLAIM OF MEDICAL NECESSITY (unless otherwise specified)**:
1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.
  2. Any charges exceeding the Allowable Charge.
  3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.

4. Services, Surgery, supplies, treatment, or expenses:
  - a. other than those specifically listed as covered by this Benefit Plan or for which a Member has no obligation to pay, or for which no charge would be made if a Member had no health benefits 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 a Member's Effective Date. Charges for Hospital services or supplies rendered or furnished during an Admission in progress on a Member's Effective Date are not covered until 12:01 AM of the Member's Effective Date unless otherwise required by law. An Admission in progress on the date the Member's coverage under this Benefit Plan ends will be covered until the date that coverage ends. The Member will not receive Benefits for any charges incurred after the date coverage ends;
  - c. rendered by a Provider who is the Member's spouse, child, stepchild, parent, stepparent or grandparent.
  - d. to the extent payment has been made or is available under any other contract issued by **HMO Louisiana, Inc.** or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law, and except for limited benefit policies;
  - e. paid or payable under Medicare Parts A or B when a Member has Medicare, except when Medicare Secondary Payer provisions apply;
  - f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures for such determinations which are on file with the Louisiana Department of Insurance;
  - g. rendered as a result of occupational disease or injury compensable under any Workers' Compensation Law subject to the provisions of L.R.S. 23:1205(C);
  - h. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; or
  - i. ordered, prescribed or rendered by a Provider who is related to a Member by blood, marriage or adoption, or who regularly resides in a Member's household.
5. Services in the following categories:
  - a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
  - b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;
  - c. those occurring as a result of taking part in a riot or acts of civil disobedience;
  - d. those occurring as a result of a Member's commission or attempted commission of a felony; or
  - e. for treatment of any Member confined in a prison, jail, or other penal institution.
6. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**
  - a. rhinoplasty;
  - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;

- c. gynecomastia;
  - d. breast enlargement, except for breast reconstructive services as specifically provided in this Benefit Plan, or breast reduction, unless determined to be Medically Necessary and as specifically provided in this Benefit Plan;
  - e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants;
  - f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;
  - g. diastasis recti;
  - h. biofeedback;
  - i. lifestyle/habit changing clinics and/or programs;
  - j. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies;
  - k. industrial testing or self help programs (including, but not limited to, smoking cessation programs and supplies, except if medically necessary due to severe lung illness such as emphysema or asthma, and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations;
  - l. recreational therapy;
  - m. primarily to enhance athletic abilities and/or
  - n. Inpatient pain rehabilitation and pain control programs
7. Services, Surgery, supplies, treatment, or expenses related to:
- a. eyeglasses or contact lenses (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered in the Schedule of Benefits;
  - b. eye exercises, visual training, or orthoptics;
  - c. hearing aids or for examinations for the prescribing or fitting of hearing aids;
  - d. hair pieces, wigs, and/or hair implants;
  - e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or
  - f. visual therapy.
8. Services, Surgery, supplies, treatment or expenses related to:
- a. any costs of donating an organ or tissue for transplant when a Member is a donor except as provided in this Benefit Plan;
  - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high dose chemotherapy to support transplant procedures;
  - c. the transplant of any non-human organ or tissue; or

- d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.
9. Regardless of Medical Necessity, Benefits are not available for any of the following, except as specifically provided for in this Benefit Plan.

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

- a. weight reduction programs;
- b. removal of excess fat or skin, regardless of Medical Necessity, or services at a health spa or similar facility; or
- c. obesity or morbid obesity, regardless of Medical Necessity, except as stated below:

Benefits will be provided for Surgery and services related to the Surgery for morbid obesity which is defined as a body mass index (BMI) greater than forty (40) or a BMI greater than thirty-five (35) with co-morbidities of clinically significant coronary artery disease, adult onset diabetes mellitus, hypertension (uncontrolled blood pressure greater than one hundred-fifty (150) systolic or ninety (90) diastolic) or major joint disease, which is attributable to the obesity. Services are available when performed in a Network Facility only.

Other services and/ or supplies for obesity and morbid obesity are not covered.

- 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, if applicable.
- 11. Services or supplies for the treatment of eating disorders, unless otherwise required by law.
- 12. With respect to late applicants, any charges for a Pre-Existing Condition for a period ending twelve (12) months after the Member's Effective Date which are incurred for a Pre-Existing Condition occurring within six (6) months immediately prior to the Member's Effective Date.
- 13. Prescription Drugs other than those administered during an Inpatient or Outpatient stay or those requiring parenteral administration in a Physician's office. The following Prescription Drugs are also excluded:
  - a. any medication not proven effective in general medical practice;
  - b. Investigational drugs and drugs used other than for the FDA approved indication, except drugs prescribed for the treatment of cancer 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;
  - c. fertility drugs;
  - d. minerals and vitamins, except for vitamins requiring a prescription for dispensation and administered during a Hospital stay or in a Physician's office;
  - e. nutritional or dietary supplements, or herbal supplements and treatments;
  - f. contraceptive drugs except as shown on the Schedule of Benefits;
  - g. contraceptive devices that do not result in permanent sterilization except as shown on the Schedule of Benefits;
  - h. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;

- i. Prescription Drugs related to a non-Covered Service; and/or
  - j. 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;
14. Coverage is not available for Prescription Drugs that can be self-administered (e.g., oral or self-injectable drugs) when obtained from a Physician or other Provider. Injectable drugs that can be self-administered are not covered when obtained from an infusion therapy provider, unless prescribed in conjunction with intravenous infusions provided by the infusion therapy provider.
  15. Sales tax or interest.
  16. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Member's home or vehicle.
  17. Charges for telephone or e-mail Consultations between a Provider and a Member, failure to keep a scheduled visit, completion of a Claim form, or to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.
  18. Palliative or cosmetic foot care; care of flat foot conditions; supportive devices for the foot, except when used in the treatment of diabetic foot disease; care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints related to the feet.
  19. Any abortion other than to save the life of the mother or if pregnancy is the result of rape or incest.
  20. Services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits.
  21. Services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.
  22. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.
  23. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.
  24. Services, supplies or treatment for cosmetic purposes, Cosmetic Surgery and any complications of Cosmetic Surgery, unless required for a Congenital Anomaly.
  25. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits.
  26. Diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition.
  27. 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.
  28. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.

29. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Benefit Plan for ; diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.
30. 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.
31. Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.
32. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.
33. Hospital charges for a well newborn.
34. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
35. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan.
36. Surgical and medical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP).
37. Paternity tests and tests performed for legal purposes.
38. Genetic testing, unless the results are specifically required for a medical treatment decision on the Member.
39. Reversal of a voluntary sterilization procedure.
40. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us; all defibrillators other than implantable defibrillators Authorized by Us.
41. Any services, supplies or treatment for complications resulting from non-covered services, except from a non-covered abortion.
42. Speech Therapy, except when performed by a speech therapist and ordered by a Physician for:
  - a. Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); or
  - b. an injury; or
  - c. a sickness that is other than a learning or Mental Disorder.
43. Sleep studies, unless obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM). If a sleep study is obtained from a facility that is not accredited by one of these bodies, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.
44. Applied Behavior Analysis (ABA) that the Company has determined is not Medically Necessary. ABA rendered to Members age seventeen (17) and older. ABA rendered by a Provider that has not been certified as a behavior analyst by the Behavior Analyst Certification Board or rendered by a Provider that has not provided, to the satisfaction of Company, documented evidence of equivalent education, professional training, and supervised experience in ABA.

## **ARTICLE XIX. CONTINUATION OF INSURANCE UPON DEATH OF THE EMPLOYEE**

### **A. Deaths on or before June 30, 1986**

Upon death of an Employee or Retiree occurring on or before June 30, 1986, coverage for the covered surviving legal spouse and Dependents will be continued until the end of the calendar month in which the Employee's or Retiree's death occurred, unless the surviving spouse and/or Dependents elect to continue coverage AT THEIR OWN EXPENSE. Application for such continued coverage must be made within sixty (60) days following the date of death.

1. The surviving legal spouse of a deceased Employee or Retiree may continue coverage until the earlier of the following:
  - a. remarriage; or
  - b. the surviving legal spouse becomes eligible for coverage under another group health plan.
2. The surviving Dependent Children of the deceased Employee or Retiree may continue coverage until the earlier of the following:
  - a. the Dependent child no longer meets the criteria for eligibility as defined under the Benefit Plan; or
  - b. the Dependent child becomes eligible for coverage under another group health plan.

**Note:** Any coverage provided by CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) shall not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or Dependent Children.

### **B. Deaths on or after July 1, 1986**

Upon death of an Employee or Retiree occurring on or after July 1, 1986, coverage for surviving Dependents shall terminate at the end of the calendar month during which the death occurs, unless the surviving covered Dependents elect to continue coverage AT THEIR OWN EXPENSE. Notification of the death must be made within sixty (60) days of the date of death. The Company will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to The Company within sixty (60) days of the receipt of the notification and premium payment must be made within forty-five (45) days of the date continuation of coverage is elected. Coverage will be retroactive to the date coverage would have otherwise terminated.

1. The surviving legal spouse may continue coverage until the earliest of the following occurs:
  - a. The applicable premium is not paid.
  - b. The spouse becomes covered under another group health plan. Effective January 1, 1990, coverage will not terminate for this reason if the new plan contains a Pre-Existing Condition limitation or exclusion for a medical condition, which the spouse had prior to the Effective Date of the new group plan. If the new group plan contains such a limitation or exclusion, the spouse may continue coverage under the Benefit Plan AT HIS OWN EXPENSE until the earlier of the following events:
    - (1) the date the Pre-Existing Condition limitation or exclusion of the new plan no longer applies; or
    - (2) thirty-six (36) months from the date coverage under the Benefit Plan would otherwise have terminated.

The spouse shall provide proof regarding the Pre-Existing Condition and the relevant provisions of the new plan upon request.

- c. Death of the surviving spouse.
2. A surviving Dependent child may continue coverage until the earlier of the following events occurs:
- a. The applicable premium is not paid.
  - b. The Dependent child becomes covered under another group health plan. Effective January 1, 1990, coverage will not terminate for this reason if the new plan contains a Pre-Existing Condition limitation or exclusion for a medical condition, which the Dependent child had prior to the Effective Date of the new plan. If the new group plan contains such a limitation or exclusion, the child may continue coverage under the Benefit Plan AT HIS OWN EXPENSE until the earlier of the following events:
    - (1) the date the Pre-Existing Condition limitation or exclusion under the new plan no longer applies; or
    - (2) the child no longer meets eligibility criteria as a Dependent under the Benefit Plan.

The child shall provide proof of the Pre-Existing Condition and of the relevant provisions of the new plan upon request.

Premiums will not exceed the premium assessed for each Employee by class of coverage under the Benefit Plan. The Company will be responsible for notifying the spouse and/or Dependent Children of the right to continue coverage upon proper notification to the Company as provided in this section and the Group will be responsible for billing and collection of the premium from the continuing persons.

### **C. Deaths on or after July 1, 1999**

The provisions of this section are applicable to surviving Dependents who elect to continue coverage following the death of an Employee or Retiree. On and after July 1, 1999, eligibility ceases for a covered person who becomes eligible for coverage in a group health plan other than Medicare. Coverage under the group health plan may be subject to HIPAA. It is the responsibility of the Group and surviving covered Dependent to notify the Company within sixty (60) days of the death of the Employee or Retiree. The Company will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Company within sixty (60) days of receipt of the notification, and premium payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.

- 1. Benefits under the plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.
  - a. The surviving legal spouse of an Employee or Retiree may continue coverage until the surviving spouse becomes eligible for coverage in a group health plan other than Medicare.
  - b. The surviving unmarried children of an Employee or Retiree may continue coverage until they are eligible for coverage under a group health plan other than Medicare, or until attainment of the termination age for children, whichever occurs first.
  - c. Surviving Dependents will be entitled to receive the same Group premium contributions as Employees and Retirees.
  - d. Coverage provided by the Civilian Health and Medical Program of the Uniform Services will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a Dependent child.
- 2. A surviving spouse or Dependent child cannot add new Dependents to continued coverage other than a child of the deceased Employee born after the Employee's death.

3. Coverage for the surviving spouse under this section will continue until the earliest of the following events:
  - a. Failure to pay the applicable premium.
  - b. Death of the surviving spouse.
  - c. On or after July 1, 1999, becomes eligible for coverage under a group health plan other than Medicare.
4. Coverage for a surviving Dependent child under this section will continue until the earliest of the following events:
  - a. Failure to pay the applicable premium.
  - b. On or after July 1, 1999, becomes eligible for coverage under any group health plan other than Medicare.
  - c. The attainment of the termination age for Children.

**ARTICLE XX. COBRA CONTINUATION OF INSURANCE**

**A. Employees: Loss of Coverage**

1. Coverage may be continued at an Employee's OWN EXPENSE if his employment is terminated voluntarily or involuntarily (except for gross misconduct), if the Employee no longer meets the definition of "Employee," or if his continued coverage under an approved leave of absence has expired. Employees terminated for gross misconduct are not eligible for COBRA. The Group must notify the Company within thirty (30) days of the date coverage would terminate due to these events and the Company will notify the Employee of his right to continue coverage within fourteen (14) days of the Group's notification to the Company. The Employee must apply for this continuation of coverage within sixty (60) days of receipt of the Company's notification and must pay the required premium within forty-five (45) days of the date the application is made. Continued coverage will be retroactive to the date coverage would have otherwise terminated.

Coverage will continue until the earliest of the following occurs:

- a. The required premium is not paid.
- b. The Employee becomes covered under another group health plan. Coverage will not terminate for this reason if the new plan contains a Pre-Existing Condition limitation or exclusion for any medical condition that the Employee had prior to the Effective Date of the new plan. If the new plan contains such a limitation or exclusion, coverage may be continued until the limitation or exclusion does not apply.

The Employee shall provide proof of the Pre-Existing Condition and of the relevant provisions of the new plan upon request.

- c. The Employee becomes eligible for Medicare.
  - d. Except as provided in "EXTENSION OF CONTINUATION," the lapse of eighteen (18) months from the date coverage would have otherwise terminated.
2. If the covered spouse and/or Dependent child of an Employee who has elected to continue coverage under this section becomes ineligible due to death of the Employee or loss of eligibility as a Dependent, the spouse and/or Dependent child may continue coverage AT THEIR OWN EXPENSE as provided in the applicable provisions of the section entitled "**CONTINUATION OF INSURANCE UPON DEATH OF EMPLOYEE**," or the paragraphs of this section entitled "**Continuation for Dependent Children**" or

**"Continuation for Divorced Spouse,"** as the case may be. However, in no event may coverage be continued beyond thirty-six (36) months from the date coverage would have ended under this section.

#### **B. Employees: Leave of Absence**

If an Employee is allowed an approved leave of absence, he may retain his coverage for a period up to, but not to exceed, one (1) year, provided the full premium is paid. Failure to do so shall result in cancellation of coverage. **The Company must be notified within thirty (30) days of the Effective Date of the leave of absence by the Employee and the Group within thirty (30) days of the Effective Date of the leave of absence.**

#### **C. Family and Medical Leave Act (F.M.L.A.) Leave of Absence**

An Employee on an approved F.M.L.A. leave may retain coverage for the duration of such leave. The Group will pay the employer's share of the premium during the F.M.L.A. leave, whether paid leave or leave without pay. The Group will pay the Employee's share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the Employee.

#### **D. Dependents of Non-Continuing Employees**

The covered spouse and/or covered Dependent Children of an Employee who does not elect to continue coverage under this section, or of an Employee on an approved leave of absence whose continuation of coverage has expired, may continue their coverage AT THEIR OWN EXPENSE, subject to the notification and termination provisions of the above paragraph. A Dependent child continuing coverage under this paragraph who loses eligibility as a Dependent and/or child may elect to continue coverage AT HIS OWN EXPENSE, subject to the notification and termination provisions of the paragraph immediately below. However, in no event may coverage be extended beyond thirty-six (36) months from the date coverage would have terminated for the Employee under this section.

#### **E. Continuation for Dependent Children**

1. An Employee or Retiree whose Dependent child loses coverage due to failure to meet the definitions of "Dependent" and/or "child" may continue coverage for the Dependent child AT HIS OWN EXPENSE. The Employee or Retiree must notify the Company of the child's loss of eligibility within sixty (60) days of the date coverage would have terminated and the Company will notify the Employee or Retiree of the right to continue coverage with respect to that child within fourteen (14) days of the date of the Company's notification. Application for this continued coverage must be made within sixty (60) days of receipt of the Company's notification and the premium paid within forty-five (45) days of the date the application is received.

Coverage will be retroactive to the date coverage would otherwise have terminated due to loss of eligibility, and will continue until the earliest of the following events occurs:

- a. The applicable premium is not paid.
- b. The Dependent child becomes covered under another group health plan. Coverage will not terminate for this reason if the new plan contains a Pre-Existing Condition limitation for a medical condition, which the child had prior to the Effective Date of the new plan. If the new plan contains such a limitation or exclusion, coverage may be continued until the limitation or exclusion does not apply or any other provision entitling the child to continue coverage becomes applicable. The child shall provide proof of the Pre-Existing Condition and of the relevant portions of the new plan upon request.
- c. The child becomes eligible for Medicare.
- d. The lapse of thirty-six (36) months from the date coverage would otherwise have terminated under the section entitled "TERMINATION OF COVERAGE."

## F. Continuation for Divorced Spouse

A covered spouse whose marriage to a covered Employee or Retiree is terminated by a legal decree of divorce may continue coverage AT HIS OWN EXPENSE. The divorced spouse must notify the Company within sixty (60) days of the date of divorce and the Company will notify the divorced spouse of the right to continue coverage under this provision within fourteen (14) days of the date of notification to the Company. The divorced spouse must apply for continuation of coverage within sixty (60) days of receipt of the Company's notification and must pay the premium within forty-five (45) days of the date the application is made. Coverage will be retroactive to the date the coverage would have otherwise terminated due to the divorce.

Continued coverage for the divorced spouse will continue until the earliest of the following events occurs:

1. The applicable premium is not paid.
2. The divorced spouse becomes covered under another group health plan. Coverage will not terminate for this reason if the new plan contains a Pre-Existing Condition limitation or exclusion for a medical condition, which the spouse had prior to the Effective Date of the new plan. If the new plan contains such a limitation or exclusion, coverage may be continued until the limitation or exclusion of the new plan does not apply.

The divorced spouse shall provide proof of the Pre-Existing Condition and the relevant provisions of the new plan upon request.

3. The divorced spouse becomes eligible for Medicare.
4. The lapse of thirty-six (36) months from the date of the divorce.

## G. Extension of Continuation

If a covered Employee or a covered Dependent is determined by Social Security to have been totally disabled on the date the Employee no longer meets the definition of "Employee," and the Employee or Dependent elects to continue coverage under paragraphs entitled "**Employees; Loss of Coverage**" or "**Dependents of Non-Continuing Employees**," coverage for the disabled Employee or Dependent may be extended AT HIS OWN EXPENSE up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated. The disabled person must submit a copy of his Social Security determination to the Company before the initial eighteen (18) month period expires and within sixty (60) days after the date the Social Security determination was issued. The Company may determine the Total Disability of a person who is ineligible for Social Security disability due to insufficient "quarters" of employment. Such person must submit proof of the Total Disability to the Company before the initial eighteen (18) month continued coverage period terminates.

Coverage under this twenty-nine (29) month extension will continue until the earliest of the following:

1. Thirty (30) days after the end of the month in which Social Security determines that the disability has ended. This determination must be reported to the Company within thirty (30) days of its issuance; or
2. Twenty-nine (29) months from the date coverage would have ended had continuation of coverage not been elected; or
3. The occurrence of any of the events listed under "**Employees: Loss of Coverage**" other than the expiration of time.

## H. Medicare: Loss of Eligibility

If an Employee becomes entitled to Medicare on or before the date such Employee's eligibility for benefits under the Benefit Plan terminates, the period of continued coverage available to the Employee's covered Dependents shall be until the earlier of the following events:

1. The applicable premium is not paid.

2. Thirty-six (36) months from the date the Employee became entitled to Medicare or, if greater, eighteen (18) months from the date coverage would have otherwise terminated had the Employee not been entitled to continued coverage under the paragraph entitled "**Employees: Loss of Coverage.**"
3. Pursuant to the other termination provisions of the paragraph entitled "**Employees: Loss of Coverage.**"

**NOTE:** In all cases of continuation, benefits shall be identical to those provided to members enrolled under the Benefit Plan under standard eligibility provisions for Actively at Work Employees and retired Employees and their Dependents.

## **ARTICLE XXI. TERMINATION OF COVERAGE**

A. Except for Members who are eligible for any of the options available for continuation of insurance under the preceding sections and who timely select continuation of coverage, coverage terminates, and Benefits will not be paid after the earliest of the following dates:

1. The date the group Benefit Plan ends.
2. The date the group Benefit Plan is changed to end insurance for the class to which the Member belongs.
3. The date the Member is no longer eligible.
4. The date that ends the monthly period for which a premium has been paid when employment with the Group ends.
5. The date that premiums or fees which are due to be paid to the Company by the Group (or the Member if required to make such contributions) and are not paid by the due date.
6. The last day of the month of a covered Employee's death.
7. The date the Member is no longer Actively at Work with the Group, except as follows:
  - a. If the Member completes his contract with the Group to the end of the school year, but ceases active work for any reason other than retirement, insurance will terminate on the September 1 on or after the date of ceasing active work. If such Employee is a professional employee with twenty-five (25) years of service with the Group, retirement on a pension plan controlled and administered by the Group does not constitute ceasing active work.
  - b. For non-professional Employees and professional Employees with less than the required years of service as stated above, the first day of the month on or after the date of retirement.
  - c. A retiree employed by another school board may be covered by either, but not both, and on termination of employment, the retiree may return to the retiree employee coverage.

B. Coverage for Dependents ends on the earliest of the following dates:

1. The same date the Employee's group coverage ends.
2. The date a Dependent, other than a legal spouse, becomes eligible as an Employee under the Benefit Plan.
3. With respect to grandchildren not in the legal custody of nor adopted by the Employee, the date the grandchild's parent loses his eligibility as a Dependent of the Employee or the grandchild ceases to meet the definition of "child."
4. The last day of the month in which the Dependent ceases to be an eligible Dependent of the covered Employee.

- C. Benefits for Hospital Health Care expenses incurred for Admissions beginning before the date of termination, will cease at the end of the Admission or the Benefit Period, whichever occurs first. All other Benefits will end on the date of termination.

## **ARTICLE XXII.**

## **COORDINATION OF BENEFITS**

### **A. Applicability**

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

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

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

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

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

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

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

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

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

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

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

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

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

### **C. Order of Benefit Determination Rules**

1. When there is a basis for a Claim under This Plan and another plan, This Plan is a Secondary Plan which has its Benefits determined after those of the other plan, unless:
  - a. the other plan has rules coordinating its benefits with those of This Plan; and,
  - b. both those rules and This Plan’s rules, in paragraph 2. below, require that This Plan’s Benefits be determined before those of the other plan.
2. This Plan determines its order of Benefits using the first of the following rules which applies:
  - a. Non-Dependent/Dependent: The benefits of the plan which covers the person as an employee, Member or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is
    - (1) Secondary to the plan covering the person as a Dependent, and
    - (2) Primary to the plan covering the person as other than a Dependent (e.g., a retired employee),then the benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.
  - b. Dependent Child/Parents Not Separated or Divorced: Except as stated in paragraph 2(c) below, when This Plan and another plan cover the same child as a Dependent of different persons, called “parents”:

- (1) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the calendar year; but
- (2) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

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

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

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

- d. **Joint Custody:** If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section C(2)(b).
- e. **Active/Inactive Employee:** The benefits of a plan which covers a person as an employee who is not terminated, laid off, or retired (or as that employee's Dependent) are determined before those of a plan which covers that person as a terminated, laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- f. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
  - (1) First, the benefits of a plan covering the person as an employee, Member or Subscriber (or as that person's Dependent);
  - (2) Second, the benefits under the continuation coverage.

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

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

#### **D. Effects on the Benefits of this Plan**

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

## 2. Reduction in This Plan's Benefits

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

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

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

### **E. Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Us any facts We need to pay the Claim.

### **F. Facility of Payment**

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

### **G. Right of Recovery**

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

1. The persons the Group has paid or for whom the Group has paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

If the excess amount is not received when requested, any Benefits due under This Plan will be reduced by the amount to be recovered until such amount has been satisfied.

## **ARTICLE XXIII. GENERAL PROVISIONS – GROUP AND MEMBERS**

### **THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP, AND ALL MEMBERS.**

**The Group is the Plan Sponsor of this Benefit Plan. HMO Louisiana, Inc. is the Claim Administrator and provides administrative Claims payment services only and does not assume any financial risk or obligation with respect to Claims liability.**

#### **A. This Benefit Plan**

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

#### **B. Benefit Plan Changes**

Subject to all applicable laws, the Group reserves the right to modify the terms of this Benefit Plan upon not less than thirty (30) days notice to the Member. No change or waiver of any Benefit Plan provision will be effective until approved by the Group’s chief executive officer or other officer authorized to make such changes.

#### **C. Identification Cards and Benefit Plan**

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

#### **D. Benefits to Which Members Are Entitled**

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan.
2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member’s Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider’s charges.
3. We may set a minimum dollar amount for Claims to be reviewed for possible Pre-Existing Conditions.

#### **E. Notice of Member Eligibility - Employer’s Personnel Data**

1. The Group is solely responsible for furnishing the information that We require for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations, and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate Us to provide Benefits under this Benefit Plan.

2. All notification of membership or coverage changes must be on forms that We approve and must include all information We require to effect changes.
3. The Group will notify Our Membership & Billing Department of a Member's termination of coverage by the end of the month for which that Member's premiums have been paid. Group will also submit to the Membership & Billing Department evidence of a Member's election of any applicable COBRA or state continuation of coverage following such termination within three business days of Group's receipt of signed continuation forms from the Member. The Company is under no obligation to refund any premium paid by the Group or any Member, if payment was made to the Company due to the Group's failure to timely notify the Company of a Member's termination of coverage.
4. The Group warrants the accuracy of the information it transmits to Us and understands that We will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as We request.
5. The Group further agrees to indemnify Us for all expenses We may incur as a result of the Group's failure to transmit correct information in the time period that We require. Indemnification includes but is not limited to Claims payments made on behalf of individuals that are not eligible for Benefits.

#### **F. Filing of Claims**

A Claim is a written or electronic proof of charges for Covered Services that a Member has incurred during the time period he was covered under this Benefit Plan. We encourage Providers to file Claims in a form acceptable to Us within ninety (90) days from the date services are rendered, but no later than fifteen (15) months after the date of service. Benefits will be denied for Claims filed any later than fifteen (15) months from the date of service. Benefit Plan provisions in effect at the time the service or treatment is received shall govern the processing of any Claim expense actually incurred as a result of the service or treatment rendered.

#### **G. Legal Action**

No lawsuit may be filed:

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

#### **H. Release of Information**

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

#### **I. Assignment**

1. The Member's rights and Benefits payable under this Benefit Plan are personal to the Member and may not be assigned in whole or in part by the Member. We will not recognize assignments or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the health plan or Us liable to any third party to whom the Member may be liable for medical care, treatment, or services.
2. We reserve the right to pay on behalf of the Group, HMOLA Network Providers, and/or Providers in the Blue Cross and Blue Shield of Louisiana Participating Provider Network directly instead of paying the Member.

#### **J. Member/Provider Relationship**

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

2. We and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. Blue Cross and Blue Shield of Louisiana does not render Covered Services but only makes payment on behalf of the Group for Covered Services that the Member receives. We are not liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider or in any Network Provider's facilities. We have no responsibility for a Provider's failure or refusal to render Covered Services to the Member.
3. The use or non-use of an adjective such as Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

#### **K. Applicable Law**

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

#### **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 Benefit Plan or under Medicare.
  - a. Where such employee or such spouse elects coverage under this Benefit Plan, this Benefit Plan will be the primary payor of Benefits with the Medicare program the secondary payor.
  - b. This Benefit Plan will not provide Benefits to supplement Medicare payments for an active employee age sixty-five (65) or older or for a spouse age sixty-five (65) or older of an active employee where such employee or such spouse elects to have the Medicare program as the primary payor.
2. Under federal law, if an active employee under age sixty-five (65) or an active employee's Dependent under age sixty-five (65) is covered under a Group Benefit Plan of an employer with one hundred (100) or more employees and also has coverage under the Medicare program by reason of Social Security disability, this Group Benefit Plan is the primary payor and Medicare is the secondary payor.
3. For persons under age sixty-five (65) who are covered under this Benefit Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Benefit Plan the secondary payor except that during the first thirty (30) month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, this Benefit Plan will be the primary payor and Medicare the secondary payor.
4. When this Benefit Plan is the primary payor, it will provide regular Benefits for Covered Services. When this Benefit Plan is the **secondary payor**, it will provide Benefits based on the lesser of: the Medicare approved amount or the Company's Allowable Charge. When an Allied Provider or Physician is not required by Medicare to accept the Medicare approved amount as payment in full, We will base Benefits on the lesser of: the Medicare approved amount plus Medicare's limiting charge, if applicable, or the Company's Allowable Charge.

#### **M. Notice**

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

## **N. Job-Related Injury or Illness**

The Group must report to the appropriate governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any legislation of any governmental unit. This Benefit Plan excludes Benefits for any services covered in whole or in part by Workers' Compensation laws and/or rendered as a result of occupational disease or injury, subject to the provisions of L.R.S. 23:1205(C). In the event that We initially extend Benefits and a compensation carrier or employer makes any type settlement with the Member, with any person entitled to receive settlement when the Member dies, or if his injury or illness is found to be compensable under law, the Member must reimburse the Group 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 Member's right for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights.
2. The Member will reimburse the Group all amounts recovered by suit, settlement, or otherwise from any third party or the Member's insurer to the extent of the Benefits provided or paid under this Benefit Plan. The Group's right to reimbursement comes first even if the Member is not paid for all of the Member's Claim for damages against the other person or organization or even if the payment the Member receives is for, or is described as for, the Member's damages other than health care expenses, or if the Member recovering the money is a minor. All costs that the Member incurs (including attorney fees) in exercising any right of recovery will be the Member's responsibility. Amounts that We paid on behalf of the Group for which a third party or insurer is responsible will not be reduced by the amount of the Member's costs. The Member shall hold in trust for the account of the Group all amounts recovered, up to the total amount of Benefits paid. The Group appoints the Member as its representative for such limited purpose only.
3. The Member will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of the Group's rights, and will take no action prejudicing the Group's rights and interest under this Benefit Plan. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Benefit Plan.
4. The Member will notify the Benefit Plan of any Accidental Injury.

## **P. Right of Recovery**

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

## **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 Group to the extent the veteran would be eligible for Benefits for such care or services from the Group 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 Group 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 Group 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 Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the “Association” permitting Us to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that We are not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Us and that no person, entity, or organization other than Us shall be held accountable or liable to the Group for any of Our obligations to the Group. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this agreement.

## **S. HIPAA Certificates of Creditable Coverage**

We shall provide, without charge, a written certification of the Member’s coverage under this Benefit Plan (HIPAA Certificate of Creditable Coverage) under the following circumstances:

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

## **T. Out-of-Area Member Liability**

### **A. BlueCard Program Member Liability – Member Provisions**

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

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

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

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

#### B. Non Participating Provider Member Liability

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

### **ARTICLE XXIV. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES**

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

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

Your Appeal rights are outlined below, after the Complaint and Grievance procedure. In addition to the Appeals rights, a Member's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of Our coverage decision when they concern medical necessity determinations. You may have the right to review your file and present evidence or testimony as part of the final internal review process.

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

#### **Complaint and Grievance Procedure:**

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

#### **To register a Complaint:**

Call Our Customer Service Department at 1-888-226-2583. We will attempt to resolve a Member's Complaint at the time of their call.

#### **To file a formal Grievance:**

A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Member does not feel their Complaint was adequately resolved or the Member wishes to file a formal Grievance, the Member must submit

this in writing. Our Customer Service Department will assist the Member if necessary. Send written Grievances to:

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

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

### **Informal Reconsideration:**

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

## **APPEAL PROCEDURES**

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

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

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

If the Member has questions or needs assistance putting the Appeal in writing, the Member may call Our Customer Service Department at 1-888-226-2583.

### **APPEAL PROCESS**

We will distinguish the Member's Appeal as either an administrative Appeal or a Medical Necessity Appeal. The procedure has two (2) levels of Appeal, the first by BCBSLA or its designee, and the second by the Member's plan administrator, (**East Baton Rouge Parish School System**). Members are encouraged to provide Us with all available information to help Us completely evaluate their Appeal.

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

### **Expedited Appeal:**

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

An Expedited Appeal is a request concerning an Admission, availability of care, continued stay, or health care service for a covered person who is requesting Emergency services or has received Emergency services, but has not been

discharged from a facility. Expedited Appeals are not provided for review of services previously rendered. An Expedited Appeal shall be made available to, and may be initiated by, the covered person or an authorized representative, with the consent of the covered person's treating health care Provider, or the Provider acting on behalf of the covered person. Requests for an Expedited Appeal may be oral or written and should be made to:

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

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

#### **First Level of Standard Appeal:**

The first level of Appeal is a process where We review denied Claims that are not of an urgent nature. The Member, his authorized representative, or a Provider acting on the Member's behalf, must submit his initial written request to Appeal one hundred eighty (180) days following the receipt of an initial adverse Benefit determination to request an Appeal. Requests submitted to Us after one hundred eighty (180) days of Company's initial denial will not be considered.

We will investigate the Member's concerns. Health care professionals, including a physician not previously involved in the initial decision, will review all Appeals of Medical Necessity denials. If We change Our original decision at the Appeal level, We will process the Member's claim and notify him and all appropriate providers, in writing, of the first level Appeal decision. If the Member's claim is denied on Appeal, We will notify the Member and all appropriate Providers, in writing, of Our decision within thirty (30) calendar days of the Member's request, unless We mutually agree that an extension of the time is warranted.

#### **Second Level of Internal Appeal:**

If We do not reverse the decision, the Member may further Appeal the denial of Benefits to the Plan Administrator. A Member who is not satisfied with the decision may initiate a voluntary second level of Appeal. Request submitted after sixty (60) days of the denial will not be considered. Send a written request for further review and any additional information to:

**East Baton Rouge Parish School System  
Attention: Grievance and Appeals Coordinator  
1050 South Foster Drive  
Baton Rouge, LA 70806**

The Member will be notified in writing of the final decision concerning his Appeal and will be given the reasons for the final decision. The Member will generally receive this notice within one hundred twenty (120) days after the Plan Administrator receives the Appeal. If the Member do not receive a notice of decision within one hundred twenty (120) days from the day the Appeal was received, the Appeal is considered denied.

The Group has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Benefit Plan.

#### **ARTICLE XXV.**

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

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

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

All of the forms mentioned in this section can be obtained from the Member's employer's personnel office, from one of Our local service offices\*, or from the home office of HMO Louisiana, Inc. The Change of Status Card has the health questionnaire on the reverse side.

If the Member needs to submit documentation to Us, the Member may forward it to Our home office at HMO Louisiana, Inc., P. O. Box 98045 Baton Rouge, LA 70898-9045, or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809.

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

### HOW TO OBTAIN CARE WHILE TRAVELING

Your I.D. card offers You convenient access to health care outside of Louisiana. If You are traveling or residing outside of Louisiana and You need medical attention, please follow these steps:

1. In an Emergency, go directly to the nearest Hospital.
2. Call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest BlueCard doctors and Hospitals.
3. Use a designated BlueCard provider to obtain benefits.
4. Present Your I.D. card to the doctor or Hospital, who will verify coverage and file Claims for You.
5. You must obtain any required Authorizations from HMO Louisiana, Inc.

### CHANGING FAMILY MEMBERS ON THE MEMBER'S POLICY

The Schedule of Eligibility lets the Member know when it is necessary for the Member to apply for coverage to enroll additional family members to the Member's policy.

The Change of Status Card is the document that We must receive in order to enroll family members not listed on the Member's original application/enrollment form. The Schedule of Eligibility will tell the Member whether We require the Change of Status Card and/or the health questionnaire. Because the Member is covered under a group insurance contract, it is extremely important that the Member follow the timing rules in the Schedule of Eligibility for making these changes to the Member's policy.

**If the Member does not complete and return a required Change of Status Card to Us so We receive it within the timeframes set out in the Schedule of Eligibility, it is possible that the Member's coverage will not be expanded to include the additional family members.** Completing and returning a Change of Status Card is especially important when the Member's first Dependent becomes eligible for coverage or when the Member no longer has any eligible Dependents.

The Schedule of Eligibility explains when coverage becomes effective for new family members. Generally, a Change of Status Card is used to add newborn children, newborn adopted children, a spouse, or other Dependents not listed on Your original application for coverage. We should receive Your completed form in Our home office within thirty (30) days of the child's birth or placement, or Your marriage.

### HOW TO FILE CLAIMS FOR BENEFITS

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

The Member's HMOLA I.D. card shows the way the name of the Subscriber (Member of the Group) appears on the Company records. (If the Member has Dependent coverage the name(s) are recorded as the Member wrote them on his application card.) The I.D. card also lists the Member's Benefit Plan number (ID #). This number is the identification to the Member's membership records and should be provided to Us each time a claim is filed.

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

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

**IMPORTANT NOTE:**

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

**ADDITIONAL INFORMATION FOR FILING SPECIFIC CLAIMS**

**Admission to a Hospital or Allied Health Facility Claims**

When the Member or an enrolled Member of the Member's family is being admitted to a HMOLA or Participating Provider, the Member should show his HMOLA I.D. card to the admitting clerk. The Provider will file the claim with Us. Payments will go directly to the HMOLA or Participating Provider. The Provider will then bill the Member directly for any remaining balance. The Member will receive an Explanation of Benefits after the claim has been processed.

**Emergency Room or Outpatient Department Claims**

The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility. However, in some instances involving Emergencies or Outpatient treatment the Provider may ask for payment directly from the Member. If this occurs, the Member should obtain an itemized copy of the bill, be sure the claim form correctly notes the Benefit Plan number (ID #), the patient's date of birth, as well as the patient's relationship to the Subscriber. The Provider must mark the statement or claim form PAID. The Member should forward this statement to HMO Louisiana, Inc.

**Claims for Mental Disorder, Alcohol and/or Drug Abuse**

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

**Other Medical Claims**

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

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

**IMPORTANT NOTE:**

*Itemized bills submitted with claim forms must include the following:*

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

**Claims for Nursing Services**

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

**Claims for Durable Medical Equipment (DME)**

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

**IF THE MEMBER HAS A QUESTION ABOUT THEIR CLAIM**

If the Member has a question about the processing or payment of a claim, the Member can write Us at the below address or the Member may call Our Customer Service Department at the number shown on Your I.D. card or any of Our Local Service Offices\*. If the Member calls for information about a claim, We can help the Member better if he has the information at hand--particularly the Group number, patient's name and date of service.

HMO Louisiana, Inc.  
P. O. Box 98024  
Baton Rouge, La 70898-9029

Remember, the Member should ALWAYS refer to his Group number in all correspondence and recheck it against the Group number on his I.D. card to be sure it is correct.

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

**ARTICLE XXVI.**

**GENERAL PROVISIONS – GROUP ONLY**

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

**A. Termination of the Group**

1. Subject to the following circumstances, We shall renew or continue provisions of administrative services at the option of the Group. We may non-renew or discontinue administrative services under this Benefit Plan only if any one of the following occurs:
  - a. Nonpayment of premiums or administrative services fees.
  - b. Fraud or intentional misrepresentations.
  - c. Failure by the Group to comply with a material plan provision to any employer contribution or group participation rules.

- d. We cease to offer coverage in the market.
  - e. In the case of Network plans, there is no longer any enrollee under the group health plan who lives, resides, or works in Our Service Area or in the area for which We are authorized to do business.
  - f. Coverage is provided through a bona fide association and the employer's membership ends.
  - g. Failure of the Group to fund Claims under this Benefit Plan.
2. Termination of this Benefit Plan may be made by giving written notice to the other party at least sixty (60) days in advance. When We give notice, it shall be by certified mail to the policyholder and shall include the reason for termination.
  3. As specified in this Benefit Plan, coverage may be terminated because of the Group's nonpayment of the current fees when due, for the Group's failure to meet eligibility requirements for coverage, or the Group's failure to perform any other obligation required by this Benefit Plan or the administrative services agreement between the parties.
  4. This Benefit Plan and all rights hereunder may be terminated by Us by written notice without the sixty (60) day requirement under paragraph 2 above, when termination is for the reason that employees have other health care coverage for which the Group either contributes or makes payroll deductions. We will designate the termination date and will not be liable for any Benefits services rendered after the date of termination.

## **B. BlueCard Plan Member Liability – Group Provisions**

Like all Blue Cross and Blue Shield Licensees, HMO Louisiana, Inc. (Company) participates in a program called "BlueCard." Whenever a Member accesses health care service outside the geographic area the Company serves, the claim for those services may be processed through BlueCard and presented to the Company for payment in conformity with Network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when a Member receives covered health care services within the geographic area served by another Blue Cross and/or Blue Shield Licensee ("Host Plan"), the Company, as the Home Plan, will remain responsible to the Group for fulfilling its contract obligations. However, the Host Plan will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its Participating Providers and handling all interaction with its Participating Providers. The financial terms of BlueCard are described generally below.

### **1. Liability Calculation Method per Claim**

The calculation of a Member's liability on Claims for covered health care services incurred outside the geographic area the Company serves and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price the Company pays the Host Plan.

The calculation of the Group's liability on Claims for covered health care services incurred outside the geographic area the Company serves and processed through BlueCard will be based on the negotiated price the Company pays the Host Plan.

The methods used to determine a negotiated price will vary among Host Plans based on the terms of each Host Plan's Provider contracts. The negotiated price that the Company pays a Host Plan on a claim for health care services processed through BlueCard may represent:

- a. the actual price paid on the claim by the Host Plan to the health care Provider ("Actual Price"), or
- b. an estimated price, determined by the Host Plan in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all Host Plan's health care Providers or one or more particular Providers ("Estimated Price"), or

- c. an average price, determined by the Host Plan in accordance with BlueCard Policies, based on billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Member and the Group from the Actual Price than would an Estimated Price.

Host Plans using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over or underestimation of past prices. However, the amount paid by the Member and the Group is the final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the Group being held in a variance account by the Host Blue, pending settlement with its Participating Providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the Group and are eventually exhausted by Provider settlements and through prospective adjustments to the negotiated prices.

Statutes in a small number of states may require a Host Blue either:

- a. to use a basis for calculating a Member's liability for covered health care services that does not reflect the entire saving realized, or expected to be realized, on a particular claim, or
- b. to add a surcharge.

Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Plan would then calculate a Member's liability and the Group's liability for any covered health care services consistent with the applicable state statute in effect at the time the Member received those services.

## 2. Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from Participating Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovering or collecting of recovery amounts. The fees of such a third-party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

## 3. BlueCard Fees and Compensation

The Group understands and agrees:

- a. to pay certain fees and compensation to the Company which is obligated under BlueCard to pay to the Host Plan, to the Blue Cross Blue Shield Association, or to the BlueCard vendors, unless the Company's contract obligations to the Group require those fees and compensation to be paid only by the Company; and
- b. that fees and compensation under BlueCard may be revised from time to time without the Group's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard.

Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Also, some of these claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to the Group as an additional claim liability. Other fees, include, but are not limited to, an 800 number fee and a fee for providing PPO Provider directories. If the Group does not have a complete listing, or wants an updated listing, of these types of fees or the amount of these fees paid directly by the Group, the Group should contact HMO Louisiana, Inc.

### **C. U.S. Economic Sanctions Laws Compliance**

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

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

## SUMMARY PLAN DESCRIPTION INFORMATION

**Name of Plan:** East Baton Rouge Parish School System (EBRPSS)

**Name and Address of Plan Sponsor:** East Baton Rouge Parish School System  
1050 South Foster Drive  
Baton Rouge, LA 70806

**Employer Identification Number (EIN):** 72-6000353

**Plan Number (PN):** 501

**Type of Plan:** Group Major Medical Benefit Plan

**Type of Administration:** The Plan's medical Benefits are administered, on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administration Services Agreement and the terms and conditions of the Benefit Plan.

**Name and Address of Plan Administrator:** East Baton Rouge Parish School System  
1050 South Foster Drive  
Baton Rouge, LA 70806  
Telephone Number: 225-922-5400  
Fax Number: 225-922-5622

**Agent for Service of Legal Process:** East Baton Rouge Parish School System  
Attention: Legal Division  
1050 South Foster Drive  
Baton Rouge, LA 70806

**Plan Year:** The financial records of the Plan are kept on a Plan Year basis. The Plan Year begins on each January 1<sup>st</sup> and ends on each December 31<sup>st</sup>.

**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.

**Source of Contributions And Funding:** The cost of all coverage is shared by the Plan Participant and the Plan Sponsor. The Participant's contributions to the Benefit Plan are at a rate determined by the Plan Sponsor.

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## HIPAA PRIVACY OF PROTECTED HEALTH INFORMATION

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**Introduction:** This group health plan document satisfies the requirements of 45 C.F.R. § 164.504(f) of the Privacy Rules for an employer or other plan sponsor to obtain plan participants' protected health information to provide plan administration functions for its group health plan. This plan document sets out the requisite "satisfactory assurance" regarding the plan sponsor's representations on the uses and disclosures of plan participants' protected health information for plan administration functions.

### **A. Purpose of Disclosure to Group**

1. The Plan and any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Group only to permit the Group to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Group of Plan participants' Protected Health Information (PHI) will be subject to and consistent with the provisions of paragraphs B. and D. of this section.
2. Neither the Plan nor any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Group unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan participants.
3. Neither the Plan nor business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Group for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Group.

### **B. Restrictions on Group's Use and Disclosure of Protected Health Information**

1. The Group will neither use nor further disclose Plan participants' Protected Health Information, except as permitted or required by the Plan Document, as amended, or as required by law.
2. The Group will ensure that any agent, including any subcontractor, to which it provides Plan participants' Protected Health Information, agrees to the restrictions and conditions of the Plan Document, including this section, with respect to Plan participants' Protected Health Information.
3. The Group will not use or disclose Plan participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Group.
4. The Group will report to the Plan any use or disclosure of Plan participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
5. The Group will make Protected Health Information available to the Plan or to the Plan participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.
6. The Group will make Plan participants' Protected Health Information available for amendment, and will, on notice, amend Plan participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.
7. The Group will track disclosures it may make of Plan participants' Protected Health Information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

8. The Group will make its internal practices, books, and records relating to its use and disclosure of Plan participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E "Privacy of Individually Identifiable Health Information."
9. The Group will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan participant Protected Health Information, in whatever form or medium, received from the Plan or any business associate servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any participant who is the subject of the Protected Health Information, when the Plan participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan participant Protected Health Information, the Group will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan participant Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

### **C. Adequate Separation between the Group and the Plan**

1. The employees, classes of employees or other workforce members identified in section D., who are under the control of the Group, may be given access to Plan participants' Protected Health Information received from the Plan or business associate servicing the Plan.
2. The employees, classes of employees or other workforce members identified in section D. will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that the Group provides for the Plan.
3. The employees, classes of employees or other workforce members identified in section D. will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Group, for any use or disclosure of Plan participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section. Group will promptly report such breach, violation or noncompliance to the Plan, as required by section B.(4.) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

### **D. Authorized Employees**

The Plan shall disclose Protected Health Information only to members 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, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer as follows:

Chief Business Operations Officer, General Counsel, Director of Finance, Chief Accountant, Budget Analyst, Supervisor of Payroll/Benefits, Supervisor of Accounting, Grants Fiscal Officer, Staff Accountant, Grants Specialist IV, Finance Specialist IV, Budget Specialist, Administrative Secretary, Finance Specialist III, Finance Specialist II, Payroll/Benefits Specialist II, Finance Specialist I, Benefits Specialist I, Accounting Specialist I and Insurance Consultant/Broker.

This list includes every employee or class of employees or other workforce members under the control of the Group who may receive Plan participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.



